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McGRAW-HILL INSURANCE SERIES
RALPH H. BLANCHARD, Editor

ACCIDENT-AND-HEALTH INSURANCE

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MARINE INSURANCE

ACCIDENT-AND-HEALTH INSURANCE

BY

EDWIN J. FAULKNER, A. B., M. B. A.

President, Woodmen Accident Company and Affiliated Companies

FIRST EDITION

THIRD IMPRESSION

McGRAW-HILL BOOK COMPANY, INC.

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ACCIDENT-AND-HEALTH INSURANCE

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To

DR. A. O. FAULKNER

a true pioneer in accident insurance

FOREWORD

By HAROLD R. GORDON

The safeguarding of human time values by means of personal accident-and-health insurance is a need recognized by everyone.

The work being performed by insurance companies in furnishing this vital protection to the American public is an outstanding achievement in the field of private business. During the past few years, the growth of personal accident-and-health insurance has been phenomenal—the volume being over 50 per cent greater today than 5 years ago.

Along with this growth has occurred a corresponding increase in home-office personnel and field representation and a demand for better training and educational programs for men and women engaged in this work.

Therefore, this publication will supply a definite need for an educational textbook and will be a reference source for factual information which all of us in the business require frequently.

I have had the privilege of reviewing Mr. Faulkner's manuscript in advance. It is clear that this book is a result of diligent research followed by a careful analysis and compilation of data, giving the reader an elementary yet comprehensive treatise on accident-and-health insurance. It not only will fill a void in the literature of accident-and-health insurance but should contribute much toward the development of a better understanding of the business both among people engaged in it and those outside it.

HAROLD R. GORDON,
Executive Secretary,
Health and Accident Underwriters Conference.

FOREWORD

By C. A. KULP

It is a pleasure to write a few words in introduction to Mr. Faulkner's book. I do not need to speak fair words on its behalf; the book speaks for itself. Mr. Faulkner, it will be seen at once, has performed a double service for accident-and-health insurance. He has brought together and placed in its setting for the first time a very considerable mass of materials, many of them unpublished, most of them widely scattered and not available to people outside the business. More significantly, his book goes considerably beyond description, a mere summing-up of trade-journal articles; it is critical in the best sense; it evaluates; to a degree still unusual in the accident-and-health insurance business, it stands off and analyzes. This quality will add immeasurably to its permanent value.

C. A. KULP,
Professor of Insurance,
University of Pennsylvania.

ACKNOWLEDGMENTS

The author wishes to acknowledge his deep indebtedness to those who have contributed so unselfishly to the preparation of the book. Dr. S. S. Huebner and Dr. C. A. Kulp, of the Insurance Department of the Wharton School of Finance and Commerce, University of Pennsylvania, gave the original impetus to the work and contributed many valuable suggestions and criticisms. Harold R. Gordon, Executive Secretary of the Health and Accident Underwriters Conference, supplied many of the data used and assisted in bringing the text into final form. Clyde Young, President of Monarch Life Insurance Company, and L. D. Ramsey, Secretary of Business Men's Assurance Company, gave the author the benefit of their counsel. Especial credit should go to Harold J. Requartte Esq. of Woodmen Accident Company for his assistance with the chapter on The Law Department. Since the literature of the field is narrowly circumscribed, much of the material used was gathered by personal interview. The following contributed freely of their time and information: Sheldon Catlin, Vice-president, Indemnity Insurance Company of North America; Kenneth Spencer, President, Globe Indemnity Company; Ray Hills, Assistant Vice-president, Great American Indemnity Company; John L. Ahern, Secretary, The Travelers Insurance Company; Lawrence Soper, Assistant Secretary, Connecticut General Life Insurance Company; Logan Bidle, Secretary, Aetna Life Insurance Company; Ralph Ferson, Assistant Secretary, Hartford Accident and Indemnity Company; Ralph Brann, Secretary, Bureau of Personal Accident and Health Underwriters; and many others. To them all and to the officers and members of the Executive Committee of the Health and Accident Underwriters Conference, past and present, sincere thanks are due for their encouragement and assistance.

EDWIN J. FAULKNER.

LINCOLN, NEB.,
April, 1940.

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ACCIDENT-AND-HEALTH INSURANCE

CHAPTER I

THE HISTORY OF ACCIDENT-AND-HEALTH INSURANCE

It is a paradox of our relatively enlightened age that *accident-and-health*, or *disability*, insurance, the field of earnings protection, should be so widely misunderstood, for no type of insurance protection relates so peculiarly to the vital personal interests of the insured.

Only a few years ago, one well-qualified authority wrote:

Commercial accident and health insurance is sixty years old, and in its present form over thirty years old. Yet its outstanding characteristics are the heterogeneity of its policy forms and the non-scientific nature of its premiums. The second, like the first characteristic, is a direct consequence of competition, which unlike competition in life and many casualty covers, devotes itself to the devising of new forms rather than to the emphasis of security and service on standard, or practically standard policies.¹

In attempting to weigh this criticism and to comprehend the reasons why for so long there was little popular appreciation of the function of disability insurance, a brief historical study of the field is of value.

The Background of Accident Insurance.—The vague beginnings of what is now known as “earnings protection” have been discerned as existing in ancient China. It was the custom among the upper classes in that land to pay the doctor as long as his patron continued in good health. Should accident or sickness overtake his client, the medical man’s compensation would stop; should his ministrations prove futile in effecting a recovery, the

¹ KULP, C. A., “Casualty Insurance,” p. 575.

executioner would relieve the doctor of his cares. Whether or not this system ever was in vogue, such a method of securing medical aid in time of distress is a far cry from present practice, although history does yield manifold evidences of definite communal arrangements for the care of the sick and injured.

As early as 1663, the Republic of the Netherlands insured soldiers engaged in its service against the loss of one or both eyes, arms, hands, legs, or feet. At a later date, in the seventeenth and early eighteenth centuries in England, the forerunners of real disability protection appeared. It was this period which witnessed the rise of marine, fire, and life insurance. Accident-and-health insurance was not known as a separate cover in that day but was issued as supplemental to one or more of the other covers. Public gambling, widely indulged in, which had its climax in the South Sea Bubble of 1720, encouraged speculation in these covers. But no true system of insurance covering disability existed.

Not until the middle of the nineteenth century did accident-insurance underwriting crystallize into a business. One might well speculate as to why disability insurance developed so many years after the life, fire, and marine coverages. It is not altogether unlikely that it was not until the introduction of machine processes and the factory technique in England in the late seven-teen hundreds and early eighteen hundreds that a real need was experienced for this type of protection. Prior to the Industrial Revolution, the average man led a rural, pastoral existence. There was nothing in the life of the time which would fasten the public consciousness upon what must have been a terrific rate of morbidity. The introduction of power machinery and of better systems of communication and transportation served to change all this. A distinctly new and increased accident hazard faced a large proportion of the people. Concurrent with the Industrial Revolution, the foundations were laid for a vast change in the accepted social philosophy. All of these factors played an undoubted part, though one which is difficult of evaluation, in making possible the institution of accident-and-health insurance.

The English Beginnings.—Judging by the type of cover first offered, it was the growth of railway travel and its consequent hazards that first centered attention upon the feasibility and

desirability of accident insurance. These hazards were spectacular, and the railway companies early realized that travel by train could be augmented and some of the popular fear of the innovation allayed, if insurance protection could be offered to those who were bold enough to venture a trip on the train. To offer such a cover the Railway Passengers' Assurance Company of London was chartered in 1848 with the cooperation of the railways. The new company issued an extra stub on the railway ticket which provided indemnity for accidental death or severe accidental injury during the course of the named journey. The Railway Passengers' was and is a remarkable company, for it is one of the very few pioneers in the field still in existence. The corporation was established on a sound financial basis with a fully paid capital of £1,000,000. It soon became apparent to the leaders of the enterprise, and particularly to William John Vian, the able and energetic secretary of the corporation from 1851 to 1890, that the railway-ticket business was too narrow a field to which to confine the company's operations. Accordingly, in 1852, and largely because of Vian's efforts, Parliament extended the Railway Passenger's charter, permitting it to write all types of accident coverage. Vian soon created his "Premium Tables for Personal Accident Insurance" which form his greatest contribution to the business. That these tables, which were the first of their kind, represent a remarkable exhibition of underwriting judgment is testified by the fact that they are still in standard use in England today.

In 1850, another organization, the Accidental Death Insurance Association of London, was set up to issue insurance to cover accidental death and injury and medical expense occasioned thereby. This organization was the first to indemnify against bodily injuries which did not occasion death. The association charged a premium of £1 for £1,000 death benefit on select risks. For £1,000 death benefit, £5 per week for total disability, and £10 medical-cost coverage, the premium was £3, 10s. The medical-cost coverage proved to be an unfortunate innovation and was promptly abandoned. The Accidental Death Association recognized the necessity for distinctions in the premium rate among risks engaged in different occupations. The early classification divided the risks into four classes:

- Class 1. Professional men
- Class 2. Master tradesmen doing no manual labor
- Class 3. The mechanics or operative classes
- Class 4. All others—the hazardous risks

Many companies have recently returned to a simple classification closely resembling this pioneer division.

Unlike its early competitor, the Railway Passengers', which prospered and grew, the Accidental Death Association was forced to reinsure and retire from the field by a series of fraudulent claims against which the company was unsuccessful in protecting itself.

Early American Development.—The year 1850 also saw the organization of what appears to be the earliest accident-insurance company in the United States. The development of health insurance somewhat antedates that of accident insurance.¹ In February, 1850, Sherman Leland and H. A. S. Dearborn, prominent citizens of Roxbury, Mass., secured a charter for their Franklin Health Assurance Company of Massachusetts. This group is believed to have been the first company to write accident insurance in this country. The company was capitalized at \$50,000. Like all early accident policies, the company's contract followed the ticket form, granting a very restricted coverage. There follows a copy of the policy:²

FRANKLIN HEALTH ASSURANCE COMPANY OF MASSACHUSETTS

Capital \$50,000

Especially empowered to insure against accidents.

This policy of insurance witnesseth that in consideration of fifteen cents paid therefor, The Franklin Health Assurance Company do assure the party whose name, with the time of purchase and delivery, is endorsed hereon, for the term of twenty-four hours from and after the date as endorsed, and promise to pay to the said party the sum of two hundred dollars provided the said party shall, during the continuance of this policy, receive any bodily injury by consequence of an accident by railway or steamboat and thereby be detained for the term of ten days; or if by such accident caused by railway or steamboat, the said

¹ See p. 15.

² FAXSON, WALTER C., "History of Accident Insurance," in "Insurance Lectures," pp. 20-21.

party shall be totally disabled from attending to any business for the term of two months next succeeding such accident and injury, this company hereby agrees and promises to pay, in lieu of the above named sum, the sum of four hundred dollars, payment to be made within thirty days after notice and proof are given to the company.

(signed) Stephen Bates, Secretary

The benefits provided by the policy appear low indeed in view of the numerous restrictions, but it must be remembered that the premium was only 15 cents.

The Travelers Insurance Company.—Although the Franklin Health Assurance Company is credited with being the earliest company in the accident field, it was not until the founding of the Travelers Insurance Company of Hartford, in 1863, that the business was instituted on a basis at all resembling its present form. While traveling in England in 1859, James G. Batterson, of Hartford, purchased at the Leamington railway station an accident-insurance ticket issued by the Railway Passengers' Assurance Corporation to cover him on his journey from Leamington to Liverpool. Batterson, an architect by profession, had traveled to Leamington to learn the methods in use at the stone quarries there. Because of his birth and rearing in and near Hartford, a city which even then was outstanding for its insurance concerns, Batterson was quite naturally interested in anything which pertained to the business of risk bearing. His curiosity was aroused by the ticket policy, and before returning to the United States he paid a visit to the Railway Passengers' offices in London. There he became acquainted with Vian, who gave him considerable information relative to the development of the business in England. He also consulted an eminent actuary, Cornelius Walford.

After returning to the United States, Batterson continued his investigations with the result that the Travelers was licensed in 1863. The original charter empowered the company to issue insurance contracts covering travel accidents only, but this was amended in June, 1864, to include accidents of every description. The minimum capital authorized by the Travelers charter was \$100,000, and this was divided into 1,000 shares of \$100 par value each. Before the company began operations, this initial capital was entirely paid in. The sound financial foundation upon which

the Travelers was built was in striking contrast to the legion of competitors which soon sprang up. The first contract of the Travelers was a verbal one between the company and one James Bolter, covering him while he walked from the Hartford Post Office to his home on Buckingham Street. The premium for this coverage was 2 cents. The first printed policy was issued Apr. 1, 1864, to Batterson to cover travel only; the first general accident policy, dated July 1, 1864, was also issued to him.

The reading of one of the early contracts issued by this company illustrates how accurately Batterson and his associates foresaw the fundamental lines along which the cover would develop as well as how their policies helped mold that development. A facsimile copy of policy 37, issued on Dec. 27, 1864, to Seth P. Norton of Collinsville, Conn., reads in part as follows:

In consideration of Ten dollars, the receipt of which is hereby acknowledged, The Travelers Insurance Company do hereby insure Seth P. Norton of Collinsville, Conn., against loss of life or personal injury in the sum of two thousand dollars, to be paid to Elizabeth E. Norton, or her legal representatives, on sufficient proof that the assured shall at any time within twelve months after the date of this policy sustain personal injury caused by any accident within the meaning of this policy, and the conditions hereunto annexed, and such injuries shall occasion death within three months from the happening thereof. And if the assured shall sustain any personal injury which shall absolutely and totally disable him from the prosecution of his usual employment, then on satisfactory proof of such injury, compensation shall be paid to him for a period not exceeding altogether twenty-six weeks for any single accident, of the rate of ten dollars per week, so long as he shall be totally disabled as aforesaid in consequence of such injury.

The exceptions contained in the policy include injuries arising from disease, surgical operation, dueling or fighting, breach of the law, and suicide or incurred during war or invasion or while intoxicated or riding in races. The insured is prohibited from travel in any state or territory then in a state of rebellion against the union without giving the company prior notice and paying an additional premium. Any question relative to the proper amount of indemnity payable might at the option of either party be referred to arbitration. The amount which the company would accept on one risk was limited to \$5,000.

The reader will perceive that in their true essentials the early contracts of the Travelers were the direct ancestors of the modern policies. Current accident-and-health policies are merely an elaboration of this old form. The premium rate which Batterson calculated for *level insurance*, i.e., \$5 per year for \$1,000 death benefit and \$5 weekly indemnity, is still the basis for accident insurance.

The Early Struggles.—In spite of the fact that they were launching an entirely new line of underwriting in a country racked by civil war, the officers of the Travelers managed so well that in its first 8 months the company received a premium income of \$49,000, having issued 2,880 policies. For the next year, the premium income stood at \$521,000; for 1866, at \$849,000. From 1864 to 1874, there occurred a series of disasters which served to fasten the public eye on accident insurance. In 1864, there were over 140 railway accidents with 404 people killed and 1,846 injured. In the 4 years ending Jan. 1, 1872, there were 526 steamship disasters in American waters which cost 1,437 lives. Those were the days of spectacular fights for control of railway properties and bitter rivalries in river and ocean navigation. Frequently, the traveling public suffered, for funds which should have been devoted to the purchase and repair of equipment went into speculative ventures and stock-market battles. These accidents cost the insurance companies a great deal of money, but the publicity incident to the disasters served to give them their first great impetus. It is said that the claim cost of these disasters nearly bankrupted the companies, but the foresight of the officers in borrowing to pay the claims and in capitalizing on the publicity pulled them through. Tribulations of this kind were common among the pioneers. Today, the great Prudential of London displays with pride a turnip-shaped silver timepiece pawned by the organizer of the company to raise funds for the payment of a claim.

By 1866, there were over 60 companies or associations actively competing in the accident-insurance field, many of which specialized in the railway-ticket policy. Competition rapidly became so intense that some remedial action was necessary. To pave the way for combination, the officers of the Travelers Insurance Company secured a charter in May, 1865, for the Railway

Passengers' Assurance Company of Hartford. Early in 1866, a consolidation of the ticket business of 10 leading underwriters was effected with the result that the Railway Passengers' of Hartford, capitalized at \$250,000, took over this field. The 10 subscribing companies shared in the stock of the Railway Passengers'. Within 5 years, the Travelers was left sole survivor and reinsurer of the 10 subscribers. Of 70 companies organized between 1865 and 1869, not a single American rival was left in 1871. The Travelers reinsured the Hartford Accident Insurance Company in 1876; and in 1878, being sole owner of the Railway Passengers' of Hartford, it dissolved that corporation and transferred the considerable business which it was doing to the ticket department of the Travelers.

The Transitional Period.—Many writers have characterized the period between 1870 and 1890 as a period of transition. During this trying time, accident underwriters began to meet the great problems which had to be solved if the business was to survive. The original simple policies were hedged about with restrictions excluding hernia, fits, vertigo, sleepwalking, taking poison, sunstroke, freezing, and intentional injuries, coverage for all of which had been read into the policy by adverse court decisions. Many fraternal associations, assessment mutuals, and industrial-accident companies were promoted during this period, but failure was their inevitable fate. Inadequate finances, improper management, and ignorance of all insurance technique were the chief stumbling blocks for many of these enterprises. Others were organized by unscrupulous individuals whose sharp practice in claim settlement brought the entire business into disrepute. In contrast to the sound practice of Batterson and his associates, many companies began business "on a shoestring"; stock would be sold on an installment-payment plan with as little as \$5 paid in on a \$100 share. Two or three large claims were enough to discourage the subscribers, and the company would fail.

Another stumbling block in the path of the pioneers was the discriminatory legislation passed in some states. Out-of-the-state companies were forced to pay heavy license fees. Pennsylvania, for instance, exacted an occupation tax ranging from \$100 to \$200 for each county in the state in addition to a 3-per

cent tax on gross premiums collected in the state. Some legislatures saw in the insurance companies a prop for their wobbly post-Civil-War credit. The companies would be required to buy for deposit with the state \$25,000 to \$50,000 of the state's bonds—an investment of questionable worth. At least one great carrier, the Knickerbocker Casualty Company which was organized in 1876, was successfully launched on its distinguished career during this time. In 1883, it was renamed the Fidelity and Casualty Company of New York under which title it still operates. It was the second company to ride out the early storms.

The oldest fraternal group, the Iowa State Traveling Men's Association, was established in 1880 and still carries on a successful business. Another pioneer, the Massachusetts Mutual Accident Association was founded in 1883 on the mutual-assessment plan. This association was later reorganized as a stock company, the Massachusetts Accident Company, and continued until its career was brought to a close by reinsurance in 1940. One of the earliest purely mutual companies which has continued to operate on the mutual basis, the Woodmen Accident Company, began business in 1890. Organized by Dr. A. O. Faulkner, a practicing physician in York, Neb., it successfully pioneered accident-insurance protection in the Middle West.

In 1891, the Aetna Life Insurance Company of Hartford sensed the growing importance of accident insurance and organized an accident department. The late Walter C. Faxon was the able leader who set up the department and headed it until his death in 1920. The Aetna's first accident policy was purchased by Morgan C. Bulkeley, president of the company, who at that time was governor of Connecticut.

The Period of Growth.—In 1890, the accident-insurance business was ready for its period of greatest growth. Competition of the fraternal, assessment mutuals, and stock companies was beginning to exert a wholesome influence in broadening the scope of the coverage and in carrying the message of accident insurance to an ever wider circle of policyholders. But in 1890 even the "giants" of the business were puny in comparison with their present size. The Travelers Insurance Company then had a capital of \$600,000 and a surplus of \$183,000; the Fidelity and Casualty, \$250,000 capital and \$61,000 surplus; the Standard

Accident of Detroit, \$200,000 capital and \$20,000 surplus. Insurance was hard to sell when the established premium of \$25 was, compared with the current price of a square meal—25 cents—tremendous.

Many companies were formed during this period. Perhaps the most noted of the early mutuals was the United States Mutual Accident Association which was managed by James R. Pitcher who began his business life as a salesman in the employ of the New York, N.Y., men's clothing store of Rogers, Peet & Co. In 1877, Pitcher organized the association with Charles B. Peet of the clothing firm as president and himself as secretary and general manager. The association attained considerable size by making its policies attractive—adding double indemnity for railroad accidents, the first policy "frill," and selling insurance to preferred risks at \$12 per year whereas the stock companies charged \$25.

In 1879, Kimball C. Atwood who was later to rise to eminence in the business entered the employ of the United States Mutual Accident Association as cashier. Six years later, he left to establish the Preferred Mutual Accident Association of which Lounsbury, former governor of Connecticut, became president and Atwood, secretary. The name of the association was changed to The Preferred Accident Insurance Company of New York in 1893 when it became a stock company specializing in the insurance of preferred risks.

In May, 1895, the United States Casualty Company began business as an outgrowth of the Guarantee and Accident Lloyds, of New York, N.Y., as well as of the Manufacturers Accident Indemnity Company, of Geneva, N.Y., both of which were later taken over by the United States Casualty Company. In 1895, the United States Mutual Accident Association was abandoned, it is said because of a dispute over Pitcher's salary, and its outstanding risks were reinsured by the United States Casualty. The Preferred Accident gave employment to many of the former employees of the old United States Mutual Accident Association.

On Dec. 31, 1899, after a decade of growth, the accident-insurance business was carried on by 47 companies with some 463,000 policies in force. They were grouped as follows, by amount of accidental-death benefit:

16 stock companies.....	\$1,627,000,000
10 fraternal societies.....	301,000,000
15 mutual associations.....	192,000,000
6 alien companies.....	98,000,000
Total.....	<u>\$2,218,000,000</u>

The condition of the business at this time is well described in the following quotation:

There was little difference in the coverage provided by the stock and mutual companies. The policy promised liberally on the initial page and on its reverse side reconsidered the generous impulse and in many of the early sessions of the organizations which were destined to bring marked improvement to the accident service, whole days were devoted to discussion of ways and means of making the courts understand that the limitations had teeth.¹

Not only did the policies leave a great deal to be desired, but the companies had little inclination to cooperate toward their improvement, as was indicated by Edson S. Lott in his address before the National Convention of Insurance Commissioners on Sept. 12, 1898, saying:

Imperfect induction is a hazard to which every accident insurance company is exposed and it is responsible for many errors in our manuals. I am trying to show that a fuller and franker intercourse between companies will necessarily improve the business of accident insurance. It is not necessary now to argue in behalf of the utility of this branch of insurance. On the other hand, no argument is necessary to demonstrate that the policies now issued are capable of improvement. But when we attempt to make changes in the direction of more comprehensive and acceptable policies, we should have the guidance of ample and reliable data.

Accident insurance, in the determination of a schedule of rates and a classification of risks, meets with much of the difficulty fire insurance contends with—the lack of cooperation of companies and reluctance to exchange experience and data from which to build a classification of hazards.²

As more companies came into the field, encouraged by the extremely lax legal requirements and supervision, competition

¹ FORREST, A. E., "Accident and Health Insurance, Past and Future," p. 5.

² *Ibid.*, p. 6.

became more intense, taking the form of wider promises to the insured. Few of the companies were strongly entrenched, so that the coverage could hardly be sold on the basis of security and service. The double-indemnity provision, introduced by the United States Mutual, was followed in 1902 by the *accumulation clause* and the *identification clause*.¹ The restrictions were withdrawn and the coverage of disability extended from 26 weeks to 52, then to 104 weeks; finally, in 1913 the Fidelity and Casualty led the companies in extending disability indemnity to cover the entire lifetime of the insured.

The Armstrong investigation in 1905 produced repercussions throughout the country by diverting business from the big Eastern companies and so encouraging the younger Western concerns. Many new influences were being felt in the business. Well-known fire-insurance companies were organizing companion companies to permit their agents to meet their clients' growing casualty-insurance needs. The Royal Indemnity Company, established in 1911, as part of the Royal-Liverpool fleet, was responsible for the introduction of the "fully accumulated policy."² This innovation was rapidly taken up by the newer companies in an effort to secure and hold the business of the older organizations. The influence of the multiple-line principle was being felt. The Fidelity and Casualty was one of the first companies to embrace this method of operation. Its action foreshadowed the rise of the modern casualty-insurance company. Accident insurance and health insurance were the first casualty lines, being followed by steam-boiler in 1866, employers'-liability in 1866, burglary in 1885, automobile in 1898, and many others.

The life-insurance companies, which up to this time had never been particularly interested in the accident-and-health business, began to enter the field. The Connecticut General Life Insurance Company set up its accident department in 1912. Another notable entry was the Metropolitan Life Insurance Company in 1921. Many of the newer companies were anxious to eliminate the undesirable frills from the coverage but were prevented from securing the necessary uniform action by some of the older

¹ See pp. 78, 80.

² See p. 80.

companies which still had many of the limited forms on their books and by some of the less scrupulous organizations which were rapacious in their drive for business. It was only in 1933 that a real step toward standardization was first taken.¹

By 1916, the business was expanding in lusty fashion, but in the fierce competition for business little constructive thought was given to serious problems which were developing. The automobile hazard was not recognized, "jumbo risks" up to \$150,000 on a single life were not unusual, reinsurance was readily available, and the underwriting was done mainly by the agent. The Standard Provisions Law² had been introduced in 1911 and was being adopted widely. Double indemnity for bicycle accidents was being eliminated. The companies were bending every effort to secure riders eliminating coverage of the war-risk hazard as it became apparent that the United States might be drawn into the World War.

Noncancelable Insurance.—A new era in the development of accident insurance commenced with the introduction of the *noncancelable* form, which is credited to G. Leonard McNeill, second president of the Massachusetts Accident Company. So far as the records show, the first absolutely noncancelable and guaranteed renewable disability policy in the United States was issued in January, 1907, by the National Masonic Provident Association of Mansfield, Ohio. The form attained prominence after 1915 when the Pacific Mutual Life Insurance Company began to push the coverage. The Pacific Mutual and the Continental Casualty Company elaborated upon the original plan. In spite of the aggressive leadership of these companies, the noncancelable form did not enjoy the success which its proponents had expected.

From the introduction of the noncancelable forms up until the depression which began in 1929, there were few startling events in the history of accident insurance. In summarizing the trend of the business from 1917 to 1927, it has been said: "The modern trend is unquestionably the trend of adaptability. Willingly through innate wisdom, or unwillingly through the force of

¹ "Report of the Governing Committee," Bureau of Personal Accident and Health Underwriters.

² See p. 86.

competition, all forces are working to the end that the needs of the policyholder shall be adequately served.”¹

The years of business recession which began in the fall of 1929 had their effect on the accident-insurance business, subjecting it to the severest strain in its history. Loss ratios skyrocketed as the companies felt the pinch of falling premium incomes, lessened production of new business, and rising claim costs. Thousands of policyholders were forced to reduce their accident-insurance protection or drop it altogether. Others, being out of work or having little incentive to return to their work, exaggerated the extent of their disabilities or attempted to convert the protection into unemployment insurance. New factors, among which may be included a changed public psychology, encouraged the less scrupulous policyholder to regard his disability insurance in a new light. “When need comes to be regarded as the equivalent of right, it is but a short step from demands upon society to claims upon private institutions.”² From a normal claim volume in 1929, the losses had increased by one-third in 1932. Death payments under accident policies rose with the number of suicides to 1½ times normal. The “jumbo lines” proved particularly unprofitable during this period, demonstrating the affinity between financial distress and the moral hazard. The trials of the early nineteen thirties were not without reward, however. From sheer necessity, the companies began to cooperate more closely than ever before. Out of the cataclysm arose a finer, more stable business, the institution of disability insurance as it is conducted today.

The depression also focused the attention of the public to a greater degree than ever before upon the costs of medical care. Hospitalization groups began to spring up to provide their members with hospital service for a nominal fee. Agitation for socialized medicine spread on a scale unprecedented for this country. To meet the competition of the hospitalization groups and satisfy a legitimate protection need of the insuring public,

¹ LILLY, AUSTIN J., “Modern Trends in Accident and Health Insurance,” *Annals of the American Academy of Political and Social Science*, March, 1927, p. 145.

² “LaMont Fiftieth Anniversary,” *Accident and Health Review*, November, 1937, p. 6.

the companies liberalized the hospital and surgical benefits offered. A large number of companies introduced complete *medical-reimbursement* coverage in their accident policies. Others adopted a more restricted type of benefit providing specified indemnities for hospital and surgical expense incurred because of either injury or sickness. When considering the turbulent history of accident insurance, it is easy, secure in the knowledge which hindsight brings, to be critical of the men who were pioneers in the business. Mistakes which now seem incomprehensible were made, and failures were numerous. But as was said in 1937:

Accident and health insurance has come through much in the last fifty years. Beginning with no guides or data, for long necessarily conducted by men of little or no experience in it, often facing the unknown and seemingly unknowable, its course was a long one of experimentation, trial and error, correction and trying some more. Perhaps there was too much experimentation, or at least embarking on new experiments before results of earlier ones were known, . . . but, today we know where we have been and where we are going.¹

Health Insurance.—At least one distinguished scholar in the field finds early indications of the idea of disability insurance as far back as the thirteenth century. Provision was made for the care and protection of seamen in sickness and distress in the ancient sea laws of Oléron and Visby, A.D. 1266–1798. The laws of Visby, a town on the island of Gotland, in the Baltic Sea, definitely required that “If the merchant obliges the master to insure the ship, the merchant shall be obliged to insure the master’s life against the hazards of the sea.” Article 7 of the laws of Oléron read that “If it happens that sickness seizes on any one of the mariners, while in the service of this ship, the master ought to set him ashore, to provide lodging and candlelight for him, and also to spare him one of the shipboys or hire a woman to attend him. . . .”² The same author traces the rise of the Friendly Societies in England on the basis of the old guild organizations. In 1757, an act of Parliament was passed providing for a system of compulsory sickness insurance for laborers engaged in unloading vessels. The Rose Act of 1793 was the

¹ *Ibid.*

² PAGE, B. A., “Accident and Health Insurance,” in “The Travelers,” p. 35.

first regulatory law tending to foster and protect the Friendly Societies in the United Kingdom. The U.S. Congress in 1798 established the U.S. Marine Hospital Service on the basis of compulsory deductions from seamen's wages.

Early Health Insurance in the United States.—As in accident insurance, the business of health-insurance protection in anything like its modern form was conceived in England and practiced through the old Friendly Societies. The evolutionary process in the United States dates from 1847. The first company which was organized to write health insurance was the Massachusetts Health Insurance Company of Boston, incorporated Apr. 21, 1847. Other companies which were organized in rapid succession to write health insurance included: The Health Insurance Company of Philadelphia, the Spring Garden Health Insurance Company of Philadelphia County, the Eagle Life and Health Insurance Company of Jersey City, the Essex County Insurance Company of Massachusetts. Like many of the early accident companies, these organizations were poorly managed and inadequately financed. Without exception, failure was their fate. The only experience upon which they could predicate their rates was that of the English societies whose methods and conditions of operation were so widely different from those of the American companies that it was of little value to them.¹ The coverage offered by these groups was restricted, and their operation is of historical interest only, since they left nothing upon which later efforts could be built. The substantial growth of health insurance began with the entry of the accident companies into the field in 1897 although it is true that some companies were writing the cover successfully before that date. For instance, the St. Lawrence Life Association issued its first combination accident-and-health policy in 1890. The Federal Life and Casualty Company of Detroit likewise provided such protection by 1891.

Later Development.—As it did in many other matters, the Fidelity and Casualty Company of New York led the stock accident companies into health insurance. The first policy was

¹ MESSENGER, H. J., "The Rate of Sickness," *Transactions of the Actuarial Society of America*, Vol. X, pp. 371-372. TARBELL, T. F., "Some Observations on Accident and Health Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. XIII, p. 47.

an experiment, conservatively undertaken. It was issued in connection with the accident policy and insured the policyholder against loss of time due to a limited number of diseases including typhus, typhoid, scarlet fever, smallpox, varioloid, diphtheria, measles, Asiatic cholera, erysipelas, appendicitis, diabetes, peritonitis, bronchitis, pleurisy, and pneumonia. A 7-day waiting period was provided, and the indemnity was limited to 26 consecutive weeks.

The way had been paved for the Fidelity and Casualty by the mutual associations. One pioneer has this to say:

There existed at this time (1885-1890) still another class of associations which pioneered in the writing of a combination accident and sickness policy, confining coverages to small monthly allowances, holding death benefits to a few hundred dollars—they were the “Benevolent” associations—and their benevolence is worthy of our praise . . . ; they blazed the trail at the risk of annihilation through a bad guess and they carried the gospel of disability insurance into homes and occupations hitherto untouched. They reached the common people, the prime object of disability insurance.¹

This authority has a plausible explanation for the early entry of the mutuals into the business of sickness insurance. He points out:

The spirit of adventure seems to have been greater in mutual than in stock company managers, perhaps because of the greater freedom of the mutual man who usually was czar of his company, the captain of his soul, with everything to gain and little to lose, while with the stock company, invested money spelled caution.²

However, once the Fidelity and Casualty had taken the step, other stock companies soon followed. In March, 1899, the Aetna Life Insurance Company and Travelers Insurance Company offered two health contracts. One was a special limited policy like the original Fidelity and Casualty cover. The other was a general health policy indemnifying the insured against loss due to temporary total disability occasioned by all diseases except

¹ FORREST, *op. cit.*, p. 6.

² *Ibid.*, p. 6.

tuberculosis, venereal disease, insanity, or disabilities due to alcohol or narcotics. This cover was issued only from the home office to select and preferred risks residing in towns of 5,000 population or larger. The premium was on the step-rate basis from \$8 per year for ages 20 to 29 to \$50 at age 50. These premiums paid for indemnity at the rate of \$5 per week, limited to 52 weeks with a 7-day waiting period. The rates were based upon the experience of the English Friendly Societies as regards the genuine amount of sickness and were then loaded for expenses and fraudulent claims. A medical examination was required. This examination and the step-rate premium made the policy unpopular, and few were sold.

The experience on the limited form, however, was surprisingly good. Almost at once, the companies were able to add to the number of diseases covered. By 1903, apoplexy, epilepsy, brain fever, hydrophobia, sunstroke, mumps, angina pectoris, yellow fever, tetanus, whooping cough, acute hydrocele, cancer, and acute cerebrospinal meningitis were included. In the same year, the general health policy was revised. All excluded diseases were eliminated from the policy. The medical examination was not required, and a schedule of surgical fees was added. The step-rate premium was abandoned, flat rates of \$7 per year for ages 18 to 50 and \$9 for ages 51 to 60 being substituted, for indemnity of \$5 per week. The other companies followed the lead of the Travelers and Aetna, and gradually the better company practice conformed to the above lines. In 1908, the 7-day waiting period was eliminated from the policy. For the next 20 years, little notable change took place in health-insurance coverage except for the introduction of the noncancelable form. The depression period beginning in 1929 took an even greater toll on sickness insurance than on accident lines because of the greater moral hazard involved. Sickness is much easier to simulate than accidental injury. Taking their cue from the lean years after 1929, some companies withdrew their health-insurance policies. There was an almost universal return to the elimination period by the commercial underwriters; and, by reducing commissions on the sickness covers, agents were discouraged from pushing the protection. Health insurance has been the child of the accident companies. Very few organizations now exist for the sale of

health insurance alone. Most of the health-insurance carriers are in some way affiliated with the accident-insurance business.

The Development of Cooperative Bureaus.—No history of the accident-and-health business would be complete without some word as to the part of the voluntary, intercompany associations. These groups have played a most constructive role in promoting the better practices of the business among the weak and scattered companies of the early days.

The first recorded instance of the meeting of accident-insurance men for the purpose of mutual interchange of ideas and the discussion of common problems was in 1891 when the managers of the accident mutuals met in Minneapolis as the Accident Section of the Association of Mutual Life Insurance Companies. At this meeting, W. K. Bellis of the Railway Officials Accident Association of Indianapolis suggested making the group a permanent one. He issued a call, and in December, 1891, at Niagara Falls, the International Association of Accident Underwriters was formed. For nearly a decade, the group was composed largely of monthly-premium assessment mutuals writing both accident and health insurance. In 1895, Bellis persuaded the association in convention at Atlanta, Ga., to acquire the services of William DeM. Hooper as paid secretary to maintain a bureau for the interchange of information and statistics. From this humble beginning, the well-known Hooper-Holmes Bureau grew. As late as 1901, only mutual companies comprised the membership of the International. In that year, Franklin J. Moore, who was president of the association, became the United States manager of the General Accident Fire and Life Assurance Company of Perth, Scotland. It was due to his persuasive influence that the stock companies began to join the group. They came in numbers—the Travelers Insurance Company, Aetna Life Insurance Company, United States Casualty Company, London Guarantee and Accident Company, the Employers' Liability Assurance Corporation—and from that day on the stock companies dominated the association.¹

At the Portland, Maine, convention in July, 1904, a committee was appointed to devise a standard classification manual. Its work was so effective and has been carried on so well that since

¹ FORREST, *op. cit.*, p. 9.

1904 nearly all companies in the United States have used the manual, or the modification of it developed by the Health and Accident Underwriters Conference, as the basis of their underwriting. Thanks to the standard manual, rate cutting has never been a serious problem, competition being almost entirely confined to policy benefits and service.

In 1911, the International amalgamated with the Board of Casualty and Surety Underwriters, a group dating from 1904, to become the International Association of Casualty and Surety Underwriters. The new group was composed of men interested in all lines of casualty insurance. Sections of the organization devoted their attention to each line of insurance. It soon developed that accident-and-health-insurance interests were not prospering under the sectional organization. Accordingly, a separate group, the Bureau of Personal Accident and Health Underwriters, was set up by the parent association. The bureau is one of the two active organizations today and, with its 40 members or more, has had a distinguished part in molding the recent development of the field.

The Health and Accident Underwriters Conference.—While the group which ultimately became the Bureau of Personal Accident and Health Underwriters was growing, another and similar association was experiencing a similar evolution. In the summer of 1898, a meeting was called in Detroit of such companies as the United States Benevolent, National Protective, Fidelity Mutual Aid, and North American Accident which had survived the vicissitudes of the nineties and were conducting a mutual, monthly-premium business. These associations were organized on the plan of \$1 per month of premium per \$1 a day of benefits, with accident indemnities payable from the first day and sickness indemnities from the eighth day. Only four companies responded to the call, and so another effort at organization was made the following November, in Chicago. D. E. Thomas of the National Protective Society, J. Bert Pitcher of the United States Health and Accident Association, L. O. Chatfield of the Phoenix Accident Association, A. E. Forrest of the North American Accident Association, W. G. Curtis of the National Casualty Company, and V. D. Cliff of the Federal Casualty Company met at the Grand Pacific Hotel to eliminate the known evils of reckless

competition and twisting. The organization accomplished little. Piracy continued, and, owing to the vast number of changes among companies, consolidations, and failures, it was not until 1902 that any real progress was made. In May of that year, D. E. Thomas of Detroit issued an invitation to some 30 of the more successful monthly-premium companies to attend a conference at the offices of his company. Ten associations were represented at this meeting by such outstanding pioneers as McNeil of Boston, Howland of Saginaw, Goodman of South Bend, Arford of Benton Harbor, and Curtis of Detroit. The keynote of the meeting was "ethics," and a series of gentlemen's agreements were drafted to regulate the worst evils of twisting and competitive policy frills. The name of "The Detroit Conference" was adopted, and the organization was perfected.¹ The Conference grew rapidly and enlarged its activities materially. Additional leaders joined, the organization including Grant of Kansas City, Boyer of Philadelphia, and Craig of Nashville. The Conference assisted in framing corrective laws, developing uniform phraseology, compiling a standard classification manual, and working out a plan for accumulating statistics of experience.

In September, 1914, the Conference was merged with the National Mutual Union and the American Association of Accident Underwriters to form the present organization, the Health and Accident Underwriters Conference. During 1917-1918, compulsory health-insurance bills were introduced in several states. The Conference organized a 5-year campaign to present the case against compulsory health insurance with the result that no bill providing such insurance was enacted into law. The membership of the Conference now includes more than 95 stock and mutual companies, fraternal societies, and commercial traveling men's associations. The influence of the Conference and its contemporary, the Bureau, has left its stamp upon the whole field of disability insurance.

¹ CLIFF, V. D., "The Origin of the Conference," p. 2.

CHAPTER II

THE FUNCTION OF DISABILITY INSURANCE

Earning Ability as a Capital Asset.—Dr. S. S. Huebner, a pioneer educator in the field of insurance at the University of Pennsylvania, is largely responsible for the conception that human life has a definite value which can be continued through the medium of insurance. Economically, the productive value of a human life is comparable to that of a valuable machine. When a business invests its funds in capital goods, the value of the machinery or equipment purchased is set up as a part of the assets of the concern. This value is amortized over the productive life of the asset, depreciation being charged periodically against it. To guarantee that the business will receive the full anticipated return from the machine, to assure the owner against loss during the useful life of the equipment, the concern takes out fire insurance, steam-boiler or machinery insurance, and business-interruption insurance.

So with a human life, there is a definite asset value which can be guaranteed only through insurance. The life of the breadwinner is the biggest asset, often the only asset, of the average family. Viewing the home and the family as a man's primary business, it is apparent that without insurance against the loss or impairment of that life value the family is vulnerable to what is often a catastrophic blow. Since the life of the breadwinner is important economically to the family because of the income which it produces, any insurance program directed toward guaranteeing that the life value will be realized should be in terms of assuring a continuation of the breadwinner's income. This end is accomplished through life and accident-and-health insurance. Four hazards to which every income producer is subject are: (1) premature natural death—dying too soon, (2) economic death—living too long, (3) disability due to accident, (4) disability due to disease. Life insurance is the instrument which affords pro-

tection against the first two hazards. By means of its policies, the family is guaranteed against the economic consequences of the husband's or father's death, and the insured himself is protected against the time when his earning days are over and he may become a burden to the family. Disability insurance finds its useful function in continuing the income of the insured during the time when, by reason of injury or illness, he is unable to work. It has a collateral function in indemnifying the insured against the heavy additional expenses which disability nearly always entails.

It is not proper to assume from the foregoing discussion of the primary purpose of the personal lines of insurance that either life or accident-and-health insurance is susceptible only to so elementary an application. The uses to which accident-and-health insurance is put are many and varied. Fundamentally, of course, the protection of income will always remain the chief function of the business. But there is a very real need on the part of non-income-producing persons for protection against losses due to disability; employers often require indemnity against interruption in the services of valued employees; and creditors, particularly under installment-purchase contracts, frequently insure the earning power of the debtor through accident-and-health insurance.

The importance of the current earning capacity of the breadwinner to the average family cannot be overemphasized. Ninety-eight per cent of the population of the United States are solely dependent upon the weekly or monthly pay check to maintain themselves. About 2 per cent of American families are affluent, having an annual income in excess of \$5,000 and a capital worth of \$50,000 or more. Twenty-six per cent of American families live on between \$1,000 and \$5,000 per year, and 72 per cent have less than \$1,000 to sustain their needs.¹ Almost without exception, the families in the latter two groups are relying entirely upon current earnings for their maintenance. A study by the Monarch Life Insurance Company of some 3,000 policyholders showed that even for a relatively secure class of people the breadwinner's income ceased when he became disabled in nearly

¹ HUEBNER, S. S., "Economic Aspects of Accident and Health Insurance," p. 3.

two-thirds of the cases examined. Either he must have insurance to protect that income, or he must gamble on his daily bread. It is altogether probable that few men or women have any conception of the total dollars-and-cents value of their working lives. Some interesting tables have been prepared showing the dollar value of income producers at different ages.¹ In establishing these somewhat theoretical average figures, weight was given, of course, not only to age and monthly income but to type of occupation and probable future lifetime as well. Typical perhaps of manual workers is the factory employee who at age 35 earns \$150 per month. The tabular value of his future earnings comes to the sizeable sum of \$30,400. A physician of the same age, netting \$300 per month, could reasonably expect to earn some \$80,300 during his remaining productive years. As an appreciation of these human-life values becomes more widespread, fewer men and women will be content to carry their own disability risks.

The Extent of Accidents and Sickness.—At any one time in the United States, between 2 and 3 per cent of the population are disabled by sickness alone. This means that over 3,000,000 people are sick in our country at all times.² Four hundred out of every 1,000 people in the country suffer from some sickness every year.³ In 1936, there were 10,811,000 separate accidents in the United States.⁴ These accidents represented 111,000 deaths, 400,000 permanently disabling injuries, and 10,300,000 temporarily disabling injuries. Sixty-eight persons meet with an accident or become ill every minute; 1 out of 7 is killed or injured every year.⁵

Intensive surveys of special groups or random samples of the population give a more detailed picture. The U.S. Public Health Service, in observing a group of 39,000 persons of all ages, found that during the course of 1 year 85 per cent complained of some-

¹ DUBLIN, LOUIS I., and LOTKA, ALFRED J., "The Money Value of a Man," pp. 171 ff.

² LELAND, R. G., "The Insurance Principle in Medicine," p. 2.

³ FALLS, LAWRENCE E., "Why Sell Accident and Health Insurance," *Insurance Index*, May, 1937, p. 14.

⁴ "Accident Facts," 1936, p. 3.

⁵ *Ibid.*, p. 14.

thing, 68 per cent consulted a doctor, 52 per cent were absent 1 day or more from work or school, and 44 per cent were confined to bed because of disability.¹ The American Medical Association reported that in 1935, 7,709,942 patients were admitted to the nation's 6,246 recognized hospitals—1 person every 4 seconds. On the average, annually, 1 of every 15 people in the country is a bed patient in some hospital. The Julius Rosenwald Fund studies show the amazingly high ratio of 662 cases of disability per 1,000 population.² The Works Progress Administration, conducting a Federal health survey in 1937, interviewed 2,660,000 persons. Basing their estimates upon an assumed national population of 130,000,000, the investigators found that there were 2,500,000 persons suffering from chronic diseases such as arteriosclerosis, heart disease, and rheumatism; 65,000 were totally deaf; 75,000 were both deaf and dumb; 200,000 had lost a hand, arm, foot, or leg; 300,000 had permanent spinal injuries; 500,000 were blind; and 1,000,000 more were lifetime cripples for other reasons.³ Nervous and mental diseases are rapidly increasing and are now the second most important cause of disability, being responsible for 12 per cent of all reported illness.⁴ Mental hospitals cared for a daily average of 383,000 persons in 1933. One-tenth of the entire population is infected with syphilis, and of these at least one-fourth are doomed to chronic invalidism or death.⁵

In 1936, of 111,000 reported accidental deaths, 39,000 occurred in the home, 38,500 were motor-vehicle accidents, 18,000 were occupational accidents, and 19,000 resulted from public accidents not involving motor vehicles. Besides the toll of deaths, no less than 10,700,000 persons were injured more or less severely.⁶

As long ago as 1925, it was estimated that each person in the United States is disabled on the average 11 days per year because of accidents and sickness. Approximately 7 days of disability

¹ DINGMAN, H. W., "Rate of Disability," p. 3.

² "Extent of Hospitalization," *Accident and Health Review*, May, 1936, p. 7.

³ "Prevalence of Accidents and Sickness," *Time*, Jan. 31, 1938, p. 22.

⁴ "Burden of Mental Disease," *Statistical Bulletin*, Metropolitan Life Insurance Company, February, 1935.

⁵ MOORE, JOSEPH E., "Syphilis," *New York Herald Tribune*, May 20, 1936.

⁶ "Accident Facts," 1936, p. 3.

were thought to be due to sickness and 4 days to accident.¹ On this basis, the American public is disabled for a total of over 1,000,000,000 days a year. Were a more recent accurate estimate available, it is conservative to assume that the total time lost would show but slight improvement.

The Cost of Disability.—It is estimated that, in 1938, accidents, resulting in injury or death, cost the American people upward of \$2,300,000,000. Of this stupendous sum, the wage loss was \$1,700,000,000, the medical expense \$300,000,000, and the overhead cost of the insurance involved \$300,000,000.² Automobile accidents alone added 1 cent to the cost of every one of the 146,000,000,000 miles driven by American motorists in 1934. It has been demonstrated that the average family faces an emergency in the form of a serious illness, surgical operation, or accident once in 11 years. The average medical cost, alone, of the emergency is figured to be \$318, or enough to wipe out the family's income for 6 weeks. The certain costs of sickness, though not so definitely determined as the accident burden, must certainly equal or exceed it. Thirteen per cent of the national income of \$35,000,000,000 derived from wages and salaries is required to pay the direct and indirect costs of disability.³

Annually, the United States loses \$12,000,000,000 because of crime, \$2,000,000,000 because of the common cold, \$1,600,000,000 through automobile accidents, \$610,000,000 from occupational accidents, \$590,000,000 because of home accidents, \$450,000,000 on account of public accidents, and \$248,000,000 because of fire losses. The common cold alone is eight times as destructive as fire.⁴ There are only 5 fires reported annually per 1,000 homes in the United States, whereas there are 120 accidents per 1,000 persons. Although the annual income of the wage and salary workers in this country has amounted to only one-sixth of the value of the property in the country, the loss of income sustained through disability is three times as great as the loss to property because of fire or windstorm—yet the amount spent to protect

¹ GORDON, HAROLD R., "Accident and Health Insurance," p. 1.

² "Accident Facts," 1939, p. 56.

³ FERGUSON, E. H., "Accident and Health Field Only Scratched," *Chicago Journal of Commerce*, Apr. 1, 1935, p. 10.

⁴ *Time*, Aug. 3, 1936, p. 24.

property against these hazards averages almost eleven times that spent for disability protection.¹

It is surprising in view of the great strides made by the medical profession and safety organizations that the rates of accident and sickness have not improved more materially. A. W. Watson, an English authority, has noted an increase in morbidity with the fall in the mortality rates. He has written:

Sickness rates are constantly rising while mortality rates except at the older ages are declining. Not only is the sickness per member at each period of life heavier than formerly was the case but a greater proportion of members survive into old age, the period of life at which sickness is at its maximum intensity.²

Although safety movements have effected a substantial reduction in occupational accidents, the rate for accidental deaths falling from 45.7 per 100,000 population in 1913 to 20.4 per 100,000 in 1938, this saving has been largely counterbalanced by the rapid increase in the number of nonoccupational accidents. The accidental death rate from all causes in 1936 reached the high point of 86.4 per 100,000 population as compared with 69.6 in 1922, 80.7 in 1930, and 78.4 in 1935. 1938 was a considerably better year, the rate being 72.2. The part that the automobile has played is illustrated by the following table:³

Year	Total accidental deaths	Motor-vehicle deaths
1913	82,460	4,227
1918	85,149	10,723
1923	84,528	18,394
1928	94,186	27,996
1933	91,087	31,363
1938	94,000	32,400

That accidental deaths are only a part of the story, and a rather small part, is indicated by the fact that for every fatal automobile accident there are 52 nonfatal disabling injuries.⁴

¹ RAMEY, JAMES, "Salesmanship in Accident Insurance," p. 7.

² LAIRD, J. M., "Non-Cancellable Accident and Health Insurance Underwriting Problems," *Proceedings of the Casualty Actuarial and Statistical Society of America*, Vol. VII, p. 322.

³ "Accident Facts," 1939, p. 59.

⁴ AHERN, JOHN E., "The Automobile Hazard in Its Relation to Accident Insurance," *Eastern Underwriter*, May 22, 1931, p. 58.

Many people will overlook the fact that all that they own, their home, their automobile, the very clothes that they wear and food that they eat, stems from one thing—their income. Too frequently, the by-products of their ability to work and earn are insured but the fundamental asset is disregarded. Herein lies the great opportunity for accident-and-health insurance, the education of the public in income protection. When it is appreciated that only 5 per cent of the incomes in the United States have been protected, the future possibilities of earnings protection are apparent.

The Services of Disability Insurance.—It is impossible to appreciate fully the institution of accident-and-health insurance without taking cognizance of the social aspect of the business. One thorough student of the line, E. H. O'Connor, has called accident-and-health insurance "the greatest social movement of the day."¹ Certainly, there can be no more enlightened system of self-help than an institution whose function is to protect the cornerstone of the home.

The benefits of disability insurance go beyond the primary function of providing a means of support for the insured and his family when injury or sickness strikes. Accident-and-health-insurance policies furnish funds to cover the expenses of medical care, thereby assuring adequate treatment which promotes prompt recovery. No small factor in putting the insured back on his feet is the relief from financial worry which accident-and-health insurance provides. So often our high-tension manner of living, our very fear of insecurity cause what we are seeking to avoid.

Our modern diseases, particularly those of the heart, are due largely to the highly sensitive energy equipment of the modern man, an equipment which leads him to throw himself against his rivals in the hope that he can make himself safe from his fellow men, safe against want, safe against a cheerless old age, only to find himself in the plight of having one of the diseases of civilization.²

To the extent that accident-and-health insurance relieves its insureds of worry over the financial consequences of disability, it

¹ O'CONNOR, E. H., "Income Insurance, the First Line of Defense for the Home," *Weekly Underwriter*, Jan. 15, 1938, p. 232.

² CRILE, GEORGE W., *Chicago Herald and Examiner*, Sept. 7, 1934, p. 10.

reduces the incidence of diseases to which worry contributes and promotes recovery.

When disabled, the income producer becomes a large-scale consumer. All the ordinary expenses continue, and in addition there are heavy additional burdens. Accident-and-health insurance is the prop which maintains the insured's credit structure. It conserves his savings. The man who has been able to accumulate a modest competence can insure his savings against dissipation because of unanticipated medical expenses by providing himself with earnings protection and expense-reimbursement insurance. Twenty-eight per cent of all loans made by personal finance companies are to pay doctor's and hospital's bills. Disability insurance literally insures other insurance. In times of emergency, it helps pay the premiums on life insurance, maintains the values of the life policy intact, avoids lapsation or surrender, and assures the completion of the life-insurance estate.

Through the principal sum or death-benefit provision, the accident policy provides a limited amount of life insurance in the event of the sudden death of the insured by accidental means. This is in reality an additional "cleanup fund" or it may be considered a projection of the insured's income for a limited time after he is removed by accidental death.

All of the foregoing beneficent functions of disability insurance are of a remedial nature. They are directed at alleviating the results of sickness and injury. They have a salutary influence not only on the insured and his family, but on the grocer, the landlord, the doctor, in fact the entire community of which the insured is a part, for the status of any society is but a reflection of the well-being of its individual members. Nevertheless, in insurance as elsewhere, the axiom "An ounce of prevention is worth a pound of cure" has a definite application. No matter how complete the insurance protection, no policy can restore a man, a house, or a machine to exactly the same state as existed before an accident. No indemnity can compensate for the anguish and suffering accompanying a serious injury or a critical illness. Steam-boiler insurance has its greatest usefulness in the inspection and servicing of risks. Liability- and workmen's-compensation-insurance companies have found that safety engineering

pays big dividends in preventing costly accidents. Dr. Huebner has estimated that every year \$3,000,000,000 in life values are sacrificed through the preventable deaths of adult workers. One-third of these could be saved for their families and society by an annual medical examination.¹ The life-insurance companies have been giving an increasing amount of attention to the health of their policyholders and the public generally. Through health education, visiting nursing services, periodic medical examinations, safety clinics, and inspections, the companies expect to retard death and decrease disability. Though the public will be the first and biggest beneficiary of any reduction in the rates of mortality or morbidity, the accident-and-health insurance companies will indirectly benefit tremendously. To a greater and greater extent, as time goes on, the greatest service of disability insurance must become the prevention of injury and sickness.

¹ HUEBNER, *op. cit.*, p. 5.

CHAPTER III

METHODS OF INDEMNIFYING FOR DISABILITY LOSSES

Disability-insurance underwriting is carried on in different ways by a wide variety of insurance carriers. The field is by no means restricted solely to companies doing an accident-and-health-insurance business. In fact, the volume of premiums written for workmen's-compensation insurance greatly exceeds that of premiums for accident-and-health insurance.

In order to be able to view accident-and-health insurance in proper perspective, it is necessary to understand in a general way the fundamentals of the other insurance lines which touch or enter the disability field. There are no less than 14 different forms in which disability insurance is written. Eight of these forms may properly be said to fall within the scope of operation of companies doing a monoline accident-and-health business or having a department devoted to that line. The other six forms, though not accident-and-health insurance, function in some manner to relieve the financial consequences of accident or sickness. The 14 forms are:

1. Employers'-liability insurance
2. Workmen's-compensation insurance
3. Workmen's collective insurance
4. Disability benefits of life insurance
5. Special contracts—Lloyd's
6. Group hospitalization plans
7. Accident-and-health insurance
 - a. Commercial
 - b. Semicommercial
 - c. Noncancelable
 - d. Industrial—weekly- and monthly-premium
 - e. Group
 - f. Travel ticket
 - g. Newspaper and similar policies
 - h. Fraternal certificates

In England disability protection in a limited form is granted under the comprehensive automobile-insurance policies issued there. Similar policies are not found in the United States.

Employers'-liability Insurance.—During the latter part of the nineteenth century, the legislatures of the various states passed employers'-liability acts whose purpose was to increase the responsibility of the employer for industrial injuries sustained by his employees. These acts were the first general recognition that industry owed a responsibility to the victims of work accidents.

The employers' liability acts amended the law of master and servant, which is a branch of the old English common law of negligence, so as to raise the level of the servant to that of a member of the general public in so far as the negligence of the employer was concerned. The law of negligence in turn is a part of the law of torts. Negligence has been defined as "the omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do or something which a reasonable and prudent man would not do."¹

If, because of the negligence of the master, the servant sustained an injury, his recourse was to sue the master under the law of negligence. The employers'-liability acts attempted to define the responsibilities of the master, providing among other things that he must: (1) furnish a reasonably safe place of work for the type of job to be done; (2) supply reasonably safe tools for the work; (3) employ fellow servants reasonably fit, competent, and sober; (4) maintain and enforce reasonable rules for the safe-conduct of the business; (5) post warnings of dangers known to him to be inherent in the employment. In the event of the injury of a servant through the failure of the master to comply with these requirements, the servant could sue and recover damages.²

The three principal defenses of the master in the event of such a suit were: (1) the fellow-servant doctrine under which the master would show that the injury was caused by the negligence of a fellow employee and through no negligence of his; (2) the

¹ THOMPSON, SEYMOUR D., "Commentaries on the Law of Negligence," Vol. I, p. 2.

² KULP, C. A., "Casualty Insurance," p. 29.

assumption-of-risk doctrine under which the employer would seek to establish that the servant was injured by reason of a hazard the consequences of which the servant accepted when he took the employment; (3) the contributory-negligence doctrine by which the employer would seek to show that the injury was sustained because of the contributory negligence of the injured servant. The employers'-liability acts somewhat restricted the extent to which the courts could admit these defenses.

Because of the uncertainty of employers as to the exact extent of their obligations under these acts, an opportunity arose for an insurance coverage which would protect the master in the event of a suit by his servant, as a result of which the employer's-liability-insurance policy was developed. Under these policies, the insurance company promises to: (1) investigate all accidents reported to it; (2) settle cases; (3) defend in the name and on behalf of the employer all claims which go to court; (4) indemnify the employer against loss "by reason of the liability imposed upon him by law for damages"; (5) pay all costs and expenses of investigation, settlement, and litigation. These policies cover injuries to all employees whose compensation is included in the employer's declaration to the company except minor children illegally employed and, more recently, employees whose work injuries may be covered under workmen's-compensation laws.

In 1911, when Wisconsin enacted the first modern state workmen's-compensation law, almost every state had an employers'-liability act on its statute books. To a large extent, however, these laws have been superseded by compensation acts and have a significant application only in the 2 states which do not have compensation laws and in connection with employments excluded from the compensation laws of the other 46 states. As a result, employers'-liability insurance, a form of third-party coverage, is no longer important in the indemnification of injuries.

Workmen's-compensation Insurance.—As the mechanization of industry in this country progressed, the problem of loss due to work injuries became acute. The injured workman's remedies under the law of negligence grew more and more unsatisfactory with the increasing utilization of machine processes. The law of negligence is founded upon the doctrine of personal fault, *i.e.*, the assumption that the blame for any work accident can be

definitely assigned. Modern industrial methods became so complex, however, that often it was difficult if not impossible to fix any negligence. The causes of work accidents to a very large degree had become social rather than individual. In addition to this underlying defect of the employers'-liability system, it had the further faults of being slow, wasteful, and a source of friction between capital and labor. Few injured workmen could afford to bring an expensive lawsuit against their employers, which even if successful might not result in a judgment commensurate with the loss. Hence, by 1900, it was apparent to enlightened opinion that some change was imperative. In recognition of the fact that most work accidents arise from social causes, in which it is impossible to fix negligence, a series of laws were passed in the several states which compelled the employer to pay benefits to employees injured by accidents sustained in the course of and arising out of their employment. These laws take note of the social aspect of the problem and seek to pass the burden of the loss on to the public through the price paid for the product or service. The Federal government enacted the first compensation law in this country in 1908. It applied only to a relatively few government employees engaged in hazardous occupations. Wisconsin, in 1911, was the first state to enact an effective law. The idea was not a new one, however; both England and Germany had long had similar systems. Wisconsin's lead was soon followed by the other states. Today all but two members of the American commonwealth, Arkansas and Mississippi, make provision for compensation.

The laws enacted in the several states vary considerably although the underlying principle is the same. The laws are far from complete, and it has been estimated that not over two-thirds of the work accidents in this country fall within the scope of the laws.¹ Various states exclude from the operation of the act all agricultural workers, domestic servants, workers in small plants, casual workers, outworkers, workers in operations not for gain, high-salaried employees, workers in interstate and foreign commerce, and many others. The benefits granted are not liberal, practically never exceeding $66\frac{2}{3}$ per cent of the wages and often being limited by a flat maximum sum and by the number of

¹ *Ibid.*, p. 127.

weeks for which benefits will be paid. Waiting periods are commonly included to eliminate trifling losses.

To qualify under an act, the injury must arise out of and be in the course of employment. It applies strictly to work accidents, although the bias of the courts and compensation administrations is invariably in favor of the worker, which has had the effect of considerably liberalizing the acts. The early compensation laws rarely covered occupational diseases. Gradually, however, the legislatures of the different states have been amending the laws to extend compensation benefits to work diseases. Some states schedule the specific diseases covered, whereas others simply state that undefined "occupational diseases" are covered.

The employer is usually required to make adequate provision for the payment of the losses to his employees either by a system of self-insurance, if he can qualify, or by securing a workmen's-compensation-insurance policy from a licensed carrier. Most statutes provide that either the employer or the employee, by filing written notice with the state compensation commission, may reject the law and elect to remain under the provisions of the common law. If the employer rejects the compensation act, however, the statute deprives him of his three primary common-law defenses in the event of suit under the law of negligence. In the past, the great majority of employers have seen fit to purchase compensation insurance to indemnify them against loss. Since 1911, a large number of insurers, stock, mutual, and reciprocal, have undertaken granting this coverage. The policy is to all intents and purposes set forth in the statute, and the administration of the benefits is also prescribed. Some notion of the importance of the line, which has been a leader among the casualty covers in point of premiums written, can be gleaned from the figures¹ shown in the table on page 36.

There is a close correlation between volume of workmen's-compensation-insurance premiums and the business cycle. Compensation premiums are based in part on the pay roll and will naturally follow the varying periods of prosperity and depression.

¹ *Best's Insurance Reports* (casualty and surety ed.), 1933, p. 785. *Ibid.*, 1936, p. 1023. *Ibid.*, 1939, p. 754. In addition a large volume of premiums is written by state funds, competitive and exclusive.

Even so brief a treatment will serve to indicate to the reader that workmen's-compensation insurance and accident-and-health insurance occupy different portions of the disability field. Workmen's compensation is largely restricted to the industrial employee, and even he is only partly protected, for vast numbers of workers are excluded from the acts and the benefits are small and are limited to occupational injuries.

WORKMEN'S COMPENSATION PREMIUMS, 1923-1938
(In millions of dollars)

Year	Stock	Mutual	Total
1923	104	31	135
1924	120	39	159
1925	134	36	170
1926	154	44	198
1927	164	48	212
1928	161	49	210
1929	171	51	222
1930	160	46	206
1931	130	37	167
1932	93	28	121
1933	89	28	117
1934	110	47	157
1935	124	62	186
1936	147	76	223
1937	172	96	268
1938	165	87	252
Total.....	2,198	805	3,003

Workmen's Collective Insurance.—A few words will suffice to indicate the part played by workmen's collective insurance in the indemnification of disability losses. This cover is somewhat similar to a group accident policy covering industrial accidents only.¹ It has been used in states not having compensation laws. The policy is usually taken by the employer who may pay all or part of the premium. The benefits provided are uniformly low, and the periods for which they are payable are limited. The amount of this cover in force has steadily declined as it has been

¹ KULP, *op. cit.*, pp. 92-94.

replaced by workmen's-compensation policies or group accident insurance, both of which offer a higher type of protection. The decline in volume of premiums for collective insurance indicates that this coverage seems to be headed for an early demise. In 1924, the carriers collected \$259,000. The premiums had decreased to \$31,000 in 1935 and to \$23,000 in 1938.¹ Workmen's collective insurance is no longer an important branch of earnings protection.

The Disability Provisions of Life-insurance Policies.—About 1900, life-insurance companies began to take steps to make their coverage more complete. For years, it has been recognized that life insurance offers only partial protection against the hazards to which human beings are exposed. In order to complete the circle of personal protection, disability insurance is necessary. The majority of human beings become totally and permanently disabled for a considerable period preceding death. The average period is about 1 year 5 months.² During this period of fatal illness, the family of the insured often must make great sacrifices to keep the insurance in force, if it can be done at all. Hence the very natural interest of the life companies in devising some means of protection to be included in the life policy whereby the insurance might be kept in force and the consequences of incapacity alleviated for the totally and permanently disabled insured.

The life-insurance disability clause was the invention of certain German companies which first issued it in 1876.³ It was an extension of the invalidity provisions found in the policies of the Continental mutual-aid and English Friendly Societies.

The Fidelity Mutual Life Insurance Company of Philadelphia issued the first disability clause in this country on Oct. 16, 1896. It provided that the insured might elect to receive either a paid-up policy or a disability annuity upon due proof of permanent and total disability.⁴ Eight years later, in 1904, the Travelers Insurance Company followed suit in granting disability coverage. By 1912, 135 companies were offering this supplemental insurance; and during the twenties all but 2 of the

¹ *Best's Insurance Reports* (casualty and surety ed.), 1939, p. 760.

² KNIGHT, C. K., "Advanced Life Insurance," p. 243.

³ *Best's Life Insurance Reports*, 1931, p. xvi.

⁴ KNIGHT, *op. cit.*, p. 246.

principal life companies had devised some form of clause for inclusion in their policies. The protection offered began as a waiver of premiums or called for the maturity of the policy in installments. This type of coverage proved inadequate and unattractive and was accordingly broadened. The more liberal clauses eventually provided for waiver of all premiums, a disability annuity of \$5 or \$10 per month per \$1,000 of life insurance, and no diminution of the principal sum payable at the death of the insured.

The clause insured against total and permanent disability only, thus differing in the scope of its protection from accident-and-health insurance. Interpretations of what constituted total and permanent disability varied, but a typical clause provided that:

If the insured, after the payment of the premiums for the first year, while the policy is in full force and before attaining the age of 65 years, shall furnish due proof that he has become wholly and permanently disabled so that he is and will be permanently, continuously, and wholly prevented thereby from performing any work, or engaging in any occupation for compensation or profit, and that the disability has existed continuously for a period of 90 days, the company will waive future premiums and pay the benefits stipulated herein.¹

Such a clause represents a very great liberalization of the talking point which was originally incorporated in the contract. Competition and judicial interpretation of the benefits effected a further material expansion in the scope of the coverage. The clause closely approximated a noncancelable disability policy, with a waiting period varying from a few days to 6 months, and covering all total disability. The extension of the presumption of permanent disability to include total disabilities of short durations carried the coverage beyond the point which the companies had contemplated; and, with the coming of bad times, the clause was often misused. The rapid extension of the disability clause had been viewed with alarm by many of the students of life insurance. By 1927, the companies had on their books policies promising yearly benefits in excess of \$3,200,000,-000.² The courts were encouraged further to broaden the cover-

¹ *Ibid.*, p. 246.

² MARSHALL, E. W., "The Disability Clause," *Annals of the American Academy of Political and Social Science*, March, 1927, p. 42.

age by the increasing liberality of the companies in their own interpretations.¹

The chief economic advantage of having the disability clause incorporated in the life policy is the saving in acquisition cost. A separate clause granting double indemnity for accidental death also became common. The coverage is easy to sell in connection with life insurance, and the underwriting is facilitated because of the medical examination required for the life policy. The history of disability insurance, particularly sickness indemnity, shows the great difficulty and expense of adjusting the multitude of small claims. For this reason if for no other, the wholesale entry of the life companies into the field of accident-and-health insurance is a very different matter from a full use of their peculiar advantages for furnishing protection against the long-term disabilities which, though relatively rare in occurrence, are of the greatest economic consequence. There is no essential conflict between the disability provisions of life insurance and personal accident-and-health policies, which cover a much wider field. But the life disability clause offers only partial protection against the hazards of accident and illness. It does not purport to cover partial or temporary total disabilities, persons over 60 or 65 years of age, substandard risks, or female risks in general. It offers no hospital, medical, or surgical benefits such as accident-and-health policies contain.

By 1928, the companies began to feel the effects of the competition and judicial interpretation which had liberalized the clause. Losses became so heavy that retrenchment was urgently necessary. At the behest of the National Convention of Insurance Commissioners, the companies agreed to follow the requirements for "standard provisions" listed below:²

1. Total disability was to be interpreted to mean inability to perform any work or follow any occupation (not merely the insured's occupation).
2. Permanent disability would not be presumed until after 120 days of total incapacity.

¹ MOIR, HENRY, "Total Permanent Disability," *Transactions of the Actuarial Society of America*, Vol. XXII, p. 464.

² GREENWALD, BENJAMIN, "Development of the Permanent and Total Disability Clause," *Best's Insurance News* (life ed.), July, 1933, p. 164.

3. Written notice of the disability must be given to the company during the lifetime of the insured and during the continuance of the disability.

4. No annuity would be given for the first 3 months of incapacity.

5. The monthly annuity would not exceed 1 per cent of the face amount of the policy.

6. No benefits would be payable after age 60.

In addition, a rate increase was put into effect. Even this program did not cure the ills, and so further restrictions were necessary. Some companies eliminated the annuity feature entirely; others reduced the benefits to one-half of 1 per cent per month. The waiting period was increased to 6 months, and the age limits lowered to 50 or 55. In spite of this further retrenchment, the business continued to be unprofitable, and many companies withdrew from the field. The excess of losses incurred and expenses paid over premiums earned by the companies licensed in New York, shown in the table below, is indicative of the general experience with the clause.¹ In the thirties alone, this excess exceeded \$410,000,000.

LOSSES ON LIFE-INSURANCE DISABILITY CLAUSES
(Companies operating in New York)

1928	\$18,000,000
1930	47,700,000
1932	63,136,000
1934	42,247,000
1936	40,379,000
1938	32,830,966
1939 (est.)	29,312,918

The principal source of these losses has not been the excess of current outgo over income but rather the necessity of adding to the reserves on old business to put them on an adequate basis. The greatest source of loss in the disability field has been the business written with the 90-day clause. It has been the purpose of the New York Insurance Department to get the reserves for the business on a more adequate basis. Some companies have even set up reserves in excess of the requirements of the department. Unfortunately, this step offers no assurance that future losses will be eliminated, for the future premiums to be paid on

¹ "Life Disability Losses," *National Underwriter*, Apr. 2, 1937, p. 2.

these policies will continue to be inadequate. The companies will be forced to make up the loss either out of surplus or by reducing the dividends on policies containing the disability feature. A number of companies have differentiated in their dividend apportionments between life policies which carry the disability clause and those which do not and have been upheld by the courts.

Much of the disastrous experience with the disability provision may be attributed to the excessively liberal coverage granted by the companies, which was further extended by judicial interpretation. The depression which began in 1929 left its mark on the benefit; for, as incomes fell, many risks were overinsured and others were completely deprived of occupation. The natural result was much malingering. The coverage practically became unemployment insurance for some. The companies' inexperience in disability underwriting contributed to their difficulties. Many good life risks, but poor disability risks, were granted lines of disability insurance entirely out of line with the principles of good underwriting.

In spite of the trials of the life companies with their disability business, the clause plays an important and necessary role in the scheme of personal insurance. Some leaders of the business feel that there is a bright future for permanent total-disability income benefits if the lessons of the past have been well learned. Dr. Harry W. Dingman has outlined the conditions on which in his opinion the companies can safely assume this type of liability.¹ (1) The applicant must be qualified physically, morally, and financially. The will to work must always be present. (2) The applicant should be a coinsurer so that it is to his advantage as well as to the company's to continue to work. An elimination period covering the first 6 months of disability, when the medical cost of accident or illness is always highest, will accomplish this. (3) Indemnities should be restricted to an amount not exceeding \$250 per month, thus avoiding luxury lines and vacation insurance. (4) A stop-loss should be imposed by limiting payments to 1 per cent per month of the face of the policy.

Other suggestions for the future development of the disability clause include: (1) the adoption of accident-and-health under-

¹ DINGMAN, H. W., "Experience in Disability Income Insurance," p. 5.

writing standards; (2) insistence that the contract be one of indemnity; (3) changing the contingency insured against from mere incapacity to work to pecuniary loss as the result of disease or accident; (4) more careful handling of claims.¹ One prominent company² has enjoyed a satisfactory experience with an unusual type of clause. It issues a supplementary contract to supply the disability benefit, defining the hazard assumed in terms of loss of income due to disability. If the average income of the insured is reduced by disability as much as 75 per cent, after 4 months of disability, total permanent incapacity is said to exist.

Notwithstanding the fact that the disability clause has been greatly restricted, most companies confining the benefits to waiver of premiums and some companies refusing to grant it at all, the part it plays in disability protection is not to be underestimated, for the companies have a great volume of it on their books.

In addition to the disability clauses the life companies are concerned with the accident-insurance field because of their double indemnity for accidental death. For a relatively small added premium, a life-insurance applicant can double the amount of the policy proceeds payable in the event he dies through accidental means. This benefit has been quite a profitable one for the companies and has presented no serious problems.

Special Contracts.—Occasionally, there is a demand for a special type of accident or health cover against a particular hazard. A musician or surgeon may desire a large amount of accident insurance on his hands, a dancer on her legs, or a lecturer may wish to insure his voice. Since corporate insurers, by and large, are not interested in these spectacular coverages, the majority of the special contracts are written through London Lloyd's. The fame of this group of underwriters who will insure against almost any hazard is widespread. In the accident-insurance business, their special contracts and catastrophe reinsurances perform a very useful function.

Lloyd's is not an insurance company in the sense that Americans usually think of a carrier. Rather, it partakes of the

¹ THURMAN, OLIVER, "Sees Income Disability Revived on Sound Basis," *National Underwriter*, Dec. 31, 1937, p. 5.

² The Mutual Benefit Life Insurance Company.

nature of a board of trade, or insurance mart, at which individual underwriters gather for the purpose of quoting rates and accepting insurance on all manner of risks. Because the amount which any single individual can underwrite is naturally limited by his personal resources, members of Lloyd's associate themselves in syndicates, each being responsible for a stated proportion of each risk underwritten by the syndicate. Different syndicates specialize in handling particular hazards. As a world market with years of experience and great resources, Lloyd's is well equipped to handle "jumbo" lines and unusual risks. Underwriters at Lloyd's are bound by but few restrictive regulations and consonant only with their famed code of honor are free to develop all manner of special coverages to meet nearly any insurance situation. Thus, Lloyd's has been a leader in providing indemnity in those unusual cases where other underwriters, lacking a wide enough exposure, have hesitated to quote rates.

Group Hospitalization.—During the period of business depression which began in 1929, hospital income from endowments and voluntary contributions decreased materially, the number of charity cases increased tremendously, and in many cases hospitals were unable to meet their obligations. Hospital managers began to cast about for additional sources of revenue. Many thought that the answer to their financial problems lay in *group-hospitalization* plans.

The purchase of hospital service on a group basis is not a new thing, but only recently has "group budgeting for hospital expenses" been strongly advocated. It has seen its most rapid development since 1931.¹ The idea was first tried by the Baylor University Hospital at Dallas, Tex., in December, 1929.² A contract was made with a group of 1,500 school teachers under which the hospital agreed to supply them with specified hospital services for a stipulated premium. The plan was successful, and the idea spread. By 1932, the city-wide, or community, plan which included all the hospitals in a given area was developed to eliminate competition between plans sponsored by individual hospitals. The principles of group hospitalization received the

¹ "Group Hospitalization," p. 7.

² ROREM, C. RUFUS, "Hospital Care Insurance," p. 2.

endorsement of the American Hospital Association in 1933. By 1937, there were 33 nonprofit, free-choice plans in operation with about 1,500,000 subscribers.

The Associated Hospital Service of New York is the largest group and is typical of the better type of plan. Some 300 hospitals in the metropolitan area cooperate with the association. The subscriber is entitled to hospitalization with semiprivate accommodations, limited to 21 days in any one year. Without charge, he is also entitled to the regular nursing service provided by the hospital, use of operating room and X-ray up to \$25 value, laboratory up to \$20 value, and such drugs, medications and dressings as his case may require. Obstetrical care is covered by the plan if the subscriber has been a member for more than 11 months. Hospitalization necessitated by pulmonary tuberculosis, contagious diseases, venereal diseases, or disabilities covered under workmen's-compensation laws or in cases not generally admissible to general hospitals is not covered by the plan.

Members are enrolled in most plans only through employee groups of five or more. The subscribing member may have the benefits extended to his wife or husband for an increased premium or to the entire family (husband, wife, and unmarried children under 17 years of age). The benefits which the subscriber receives are all in the form of hospital service. No cash payments are provided except in some instances where an allowance is made when the member is necessarily hospitalized while outside the community serviced by his group. The hospital is reimbursed for the services rendered, by the administration of the group at a predetermined contract rate.

The experience, methods, and effect of group-hospitalization plans upon the business of disability insurance will be discussed in a later chapter.¹ The significant feature of the plans is the service nature of the contract as distinguished from the cash-indemnity type of contract issued by the insurance companies. The benefits of the hospital groups are restricted solely to hospital service and unlike accident-and-health insurance do not cover loss of time, accidental death, or any type of indemnity other than hospitalization. Supplementing the group-hospitalization plans, however, experiments have been begun in a number of localities

¹ See Chap. XIII.

with organizations whose purpose is to furnish complete medical service on a group, prepayment basis.

Accident-and-health Insurance.—The most complete coverage against the financial consequences of disability is offered by accident-and-health insurance. While the other forms in which disability insurance is written are designed to afford protection against particular hazards, accident-and-health insurance has for its field the broad indemnification of lost earnings and expense caused by injury or sickness. Such indemnity is provided under eight different types of cover.

Commercial Policies.—Policies of the commercial type of accident-and-health insurance are issued to individuals and are characterized by comprehensive coverage, liberal indemnities, and high limits. Only select and preferred risks whose occupational hazard is slight are eligible for this form. Many companies specialize in underwriting commercial policies which have been designed to meet the protection requirements of the business, professional, and clerical classes. Commercial accident-and-health-insurance contracts customarily provide for annual premium payments.

Semicommercial Policies.—Although somewhat more restricted than commercial policies, semicommercial or quarterly-commercial policies follow the same general pattern. Semicommercial contracts are issued to risks in all insurable occupational classifications to provide wide coverage but with lower limits and in smaller amounts than the commercial forms. Premiums are usually payable quarterly.

Noncancelable Policies.—Noncancelable accident-and-health policies are distinguished from commercial forms, which they closely resemble, because the carrier cannot retire from the risk by cancelation and the option of renewal up to a designated age is vested solely in the insured. Mere omission of Standard Provision 16, which gives the carrier the right to cancel during the policy term, is not sufficient to make the cover truly "non-cancelable"; it must also guarantee to the insured the right to renew the contract from term to term. Noncancelable policies are restricted to risks engaged in nonhazardous occupations.

Industrial Policies.—The principal characteristic of industrial accident-and-health-insurance policies is the weekly or monthly

mode of premium payment. Designed to furnish income protection for the manual worker, industrial policies provide substantial coverage on an individual basis for a small premium. Benefits are necessarily more restricted in limit and amount than under commercial or semicommercial forms.

Group Policies.—Disability protection of varying types is provided for a large number of risks under a single cover by group policies. A master contract is issued to the employer, association, or union securing protection for its employees or members without the benefit to the carrier of individual selection of risks. Each member of the insured group receives a certificate of insurance subsidiary to the master contract. Premiums may be paid in whole or in part by the employer or association. In most group plans, however, the individuals covered contribute to the payment of the premium by deductions from pay roll or by additional dues. Group accident-and-health-insurance benefits are less liberal than the indemnities provided by individual covers.

Travel-ticket Policies.—In their present form, travel-ticket policies offer the same liberal protection as regular commercial or semicommercial policies. They differ from these forms in the length of the policy term, being issued for short periods of time—24 or 48 hours, 1 week, 1 month, or 3 months. Travel-ticket policies are so called because they were originally issued as an extra stub on a railway ticket. They are still most widely sold at railway stations, airports, and hotels to travelers who desire coverage for the duration of a journey.

Newspaper and Similar Policies.—Limited coverage is provided for a nominal premium through newspaper and similar accident-insurance policies. The cover defines the circumstances under which indemnities will be paid. Frequently, as a circulation builder, newspapers will arrange with a carrier to issue a limited policy to its readers, application being made on the simple form printed in the newspaper. There is also a wide variety of limited accident-insurance policies which enumerate the specific hazards covered.

Fraternal Certificates.—Some fraternal societies grant their members the privilege of receiving benefits if they become disabled. A fraternal certificate is the statement of an individual's

membership in the society and outlines the benefits and conditions under which he is entitled to receive indemnity.

Extent of Accident-and-health Insurance.—Employers' liability insurance, workmen's-compensation insurance, life disability benefits, and group-hospitalization plans all play an important part in the alleviation of the financial consequences of disability, but each occupies only a segment of the field. None offers the complete protection which is available through the different forms of accident-and-health insurance. The other types have been developed to meet special problems or cover special types of disability, and none can approach accident-and-health insurance in the adequacy with which it meets the whole problem of loss due to disability.

Although for many years accident insurance was the premier casualty line from the standpoint of premiums written as well as the oldest casualty cover, today it is outranked in volume by two of the newer lines. Both workmen's-compensation insurance and automobile public-liability insurance produce more premiums than accident-and-health insurance. In 1928, of some \$883,000,000 in net premiums earned by casualty companies reporting to A. M. Best and Company, workmen's compensation accounted for 31.4 per cent, automobile public liability for 25.8 per cent, and accident and health for 12.2 per cent. In 1938, of \$1,026,000,000 net casualty premiums reported, automobile public liability earned 23.5 per cent, workmen's compensation 24.3 per cent, and accident and health 14.4 per cent.¹ The volume of accident-and-health premiums reported in this analysis, however, totaled only \$148,800,000 for 1938 whereas the Health and Accident Underwriters Conference complete compilation shows that for all companies the premiums that year amounted to \$222,906,000. If the very considerable volume of premiums omitted from the comparison above were to be included, the accident-and-health total would approximate 20 per cent of the entire casualty-insurance volume.

Accident-and-health insurance is sold by more than 325 different companies, associations, and societies in this country. Of these, about two-thirds operate on the stock-company plan, whereas the others are mutual companies, assessment associa-

¹ *Best's Insurance Reports* (casualty and surety ed.), 1939, p. 761.

Year	Premiums written	Losses paid	Loss ratio, %
1934	\$164,653,000	\$95,167,000	57.79
1935	174,601,000	99,433,000	56.94
1936	191,951,000	103,478,000	53.90
1937	214,024,000	107,580,000	50.26
1938	222,906,000	115,295,000	51.72
1939 (est.)	240,000,000	124,800,000	52.00

tions, or fraternal societies. These organizations run the whole gamut of size and strength from companies with less than \$2,000 in admitted assets and with a few hundred members to gigantic concerns with billions of dollars of assets and many thousands of policies in force. In 1938, the premium volume of the different insurers ranged from less than \$1,000 to \$18,260,000, the amount of accident-and-health premiums reported by the Metropolitan Life Insurance Company, which is the largest single underwriter in the business. Forty-eight companies wrote over \$1,000,000 in premiums each and 21 companies over \$2,000,000.

STOCK COMPANIES

(Accident-and-health premiums written in millions of dollars)

Year	Accident	Health	Noncancelable	Nonsegregated
1923	36	20	30
1924	38	20	0.4	34
1925	41	19	10	29
1926	43	20	11	38
1927	44	21	12	38
1928	44	21	13	51
1929	45	22	14	51
1930	45	21	18	47
1931	42	18	17	45
1932	34	14	17	34
1933	30	12	14	31
1934	32	13	15	32
1935	33	15	15	33
1936	36	16	14	40
1937	41	20	16	43
1938	39	19	16	48

The table shown at the top of page 48 gives a fairly complete compilation of premiums and losses for the 5-year period 1934-1939.¹

The trend in amount of premiums during the period 1923-1938 is shown by the course of the combined totals for stock underwriters during these years. The figures in the table at bottom of page 48, though pertaining to only a part of the industry, trace the pattern of the business done during these years.²

Notwithstanding the fact that accident-and-health insurance is no longer the largest casualty line, it is of major importance. The average premium is low, ranging from \$30 to \$35 for some companies writing the commercial forms to \$10 or \$15 for some of the industrial companies.

With the public's increasing appreciation of the benefits of accident-and-health insurance, there is every reason to believe that the premium trend will continue upward for many years to come.

¹ *Health and Accident Underwriters Conference Bulletin*, November, 1939.

² *Best's Insurance Reports* (casualty and surety ed.), 1933, 1939.

CHAPTER IV

TERMS OF POLICY

A former president of the National Convention of Insurance Commissioners has said:

Health and accident insurance, a full brother to life insurance, is doing more to alleviate suffering, reduce the evils of want and poverty, revive drooping spirits, and keep the home fires burning, than any other business in the world. It is a glorified philanthropy, giving help when most needed, paying while you live, helping others to help themselves, bridging the gap between sickness and health, between disability and strength, keeping the life insurance policy in force and keeping the American family together without the humiliation of charity. It protects the greatest human asset—the earning power of the individual.¹

What is the nature of the contract whose provisions embody the means of performing the noble missions to which Commissioner Brown refers? Some of the development of the modern policy was sketched in the first chapter. The best coverage today is the result of a long and tortuous evolution, and the field is still marked with policies which are survivals of past stages in the growth of the business. In a recent survey of over 300 policies issued by some 50 companies, no 2 were found exactly alike. A strong tendency toward uniformity is apparent in the essential clauses of policies issued by the larger companies, but the content of the miscellaneous and benefit provisions is limited only by the fertile imagination of the underwriter. Much of this diversity in the coverage is directly traceable to the competitive growth of the business. Some companies have had as many as 25 or 30 contracts for sale at the same time. Since accident-and-health insurance is sold by more types of carrier than any other insurance line, there is bound to be a wide variety of policy forms, particularly as each company has tried to have something of a distinctive nature in its policies to attract sales. Fortunately,

¹ BROWN, GARFIELD W., "Public Confidence—The Great Insurance Reserve," p. 4.

health insurance is less affected in this respect than the older accident line, owing principally to the fact that its major development was in the hands of men who had already acquired experience in accident insurance.

The problem of the underwriter in drafting a contract today is chiefly one of precision of statement:

The policy is a contract of numerous and varied undertakings. All of its many provisions are involved in the problem of finding means of expressing true and legitimate intent and, in the light of technical interpretations by the courts, both sound and sophistical, and of practical misunderstandings by the public, both sincere and wily, of making each mean what it is intended to mean.¹

The form of the policy tends to vary according to the type of organization issuing it. The problem of analyzing the coverage offered in the field of personal accident-and-health insurance is the more difficult because the groups in the field are both stock and mutual—including stock and mutual monoline accident-and-health companies, multiple-line casualty companies, life companies with accident-and-health departments, commercial traveling men's associations, and fraternal-benefit societies. Each organization may issue a number of contracts indemnifying against accident alone, health alone, or both in combination. The stock companies issue nonparticipating contracts for a stipulated premium, securing their business through an agency organization. For the most part, the monoline mutual accident-and-health, mutual life, and multiple-line casualty companies follow the same scheme, employing a regular agency system. The power of assessment is usually contained in their contracts (except those of life companies) although some mutuals operate under a stipulated-premium law much in the same fashion as do the mutual life companies. A few mutual companies issue participating contracts, but the usual procedure is to allow whatever profit may accrue to accumulate as part of the company's surplus. The traveling men's associations operate on the assessment plan depending largely upon direct-mail solicitation of new members. The fraternal-benefit societies are assessment organizations, represented in the field by a deputy system.

¹ LAMONT, STEWART M., "Constructing and Construing Policy Contracts," p. 2.

In the ensuing analysis, an effort has been made to select the most representative coverage. Significant departures from the selected coverage will be noted.

The Application.—Although the *application* does not come first in the physical arrangement of most contracts and only becomes a part of the contract after the risk is accepted, it should be discussed first since it is the basis of the contract. In many casualty lines, it is not customary to require a formal, signed application. This practice makes for flexibility and expedites the granting of the coverage.¹ However, in accident-and-health insurance, where the nonmedical form prevails, it is the custom to secure a full and accurate description of the risk over the applicant's signature. Some companies writing the limited, newspaper type of policy practically do without the application, for the proposal form sent in by the applicant contains little information aside from name, address, age, sex, and occupation. For a while during the earlier years of the twentieth century, the companies attempted to dispense with the formal application, but the evils of inaccuracy and twisting made a return to the former practice seem desirable. Impetus was given to the use of a formal application by the enactment of the Standard Provisions laws which provide, among other things, that the policy and attached or endorsed papers, if any, constitute the entire contract of insurance.

The application is a proposal for insurance by the applicant to the company. Until accepted, no liability inures to the company. Formerly, the statements in the application were construed as warranties, and the applicant was held strictly accountable for their literal accuracy. Since this practice led to a good deal of abuse in the settlement of claims, many states enacted laws providing that the applicant's answers were simply representations and that the policy would be void only if false statements in the application were made with intent to deceive or materially affected either the acceptance of the risk or the hazard assumed.² The carriers seek to impress upon the applicant the importance of giving correct information in the proposal

¹ MICHELbacher, G. F., "Casualty Insurance Principles," p. 164.

² LaMONT, STEWART M., "The Contract of Personal Accident and Health Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. XVIII, p. 50.

for insurance by including a question bearing upon the right of the company to deny liability in the event of the applicant's misrepresentation of the risk. The wording most generally used in the past is: "Do you agree that the falsity of any answer in this application for a policy shall bar the right to recover thereunder if such answer is made with intent to deceive or materially affects either the acceptance of the risk or the hazard assumed by the company?"

A somewhat simpler question which accomplishes about the same result as the foregoing and is gaining wider acceptance is: "Do you represent each and all of the foregoing answers to be true and complete?"

The first section of the application deals with the identification and description of the insured. Full name, age, date and place of birth, height, weight, sex, and color are all asked for. This information is required both because it is necessary to the underwriting of the risk and as a means of preventing confusion between insureds with the same or similar names. The occupation, the employer, and an exact description of the applicant's duties are next asked for. This information is used in assigning the proper occupational classification and in checking at the time of claim settlement. Usually, information concerning the beneficiary is next in order. The full name, address, and relationship are required. The beneficiary must have an insurable interest in the applicant. Ordinarily, a contingent beneficiary is not named since the right to change and successively change beneficiaries is reserved to the insured by Standard Provision 13.

A section of the application is devoted to the previous insurance history of the applicant. A description of existing accident-and-health contracts, contracts previously held but no longer in force, and any claims paid for disability is requested. The companies in recent years have been giving more attention to the effect of workmen's-compensation, group-hospitalization, and life-insurance-disability benefits upon the problem of overinsurance. Some have inserted questions in the application inquiring as to the amount of such benefits to which the applicant would be entitled in the event of disability. The company is also interested in any adverse actions which other insurers have taken relative to granting or continuing coverage on the insured. A

APPLICATION—Accident and Health Department—Zenith Indemnity Company

Name of Policy				Form Letters		Class.		Branch Office or Agency at	
Principal Sum		Weekly Indemnity		Med. Reim.	Premium	Sick.	Agent		
\$		Accident							
Capital Sum		\$		\$		Term		Sub-Agent	
\$		\$		\$		Mos.			
Date of Policy (To be filled in by Policywriter) 19 ..									
Residence Address				Street		City or Town of		State of	
Business Address				Street		City or Town of		State of	
Member of Firm of or Employed by						Business Engaged in			
Policy No.									
H.O. Entry No.									
Br. Entry No.									
CODES									
Agt. or Br.									
State Em.									
Dec.									

Application to Zenith Indemnity Company					
A	What is your full name?		Age?	Sex?	
B	Color?	Height?	ft.	in.	Weight? lbs.
C	What is your occupation and duties?		Date of birth?		Place of (State or Country) birth?
D	To whom shall policy and/or any accrued benefits thereunder be payable in case of death?		Name of Beneficiary?		Address?
E	Do your average weekly earnings exceed the aggregate single weekly indemnity payable under this and similar policies carried by you?		Relationship to you?		
F	What accident or sickness insurance have you in this Company or in other companies or associations?		Have you ever received indemnity for any injury or sickness?		

MEMO.

FULL INFORMATION

statement of the average weekly earnings or to the effect that the earnings exceed all insurance applicable to the risk is required in order to check for overinsurance. The insurance history is important in that it permits the company to investigate the applicant's status with other companies, assists in preventing overinsurance, and guards against a chronic malingerer securing an opportunity to file further questionable claims.

A large portion of the application is concerned with the physical risk and medical history of the applicant. He is asked if he has any special journey or hazardous undertaking planned, if he engages in aeronautics or motorcycling. Some companies insert a question as to whether he drives an automobile. In a sickness-only application, the interrogations relative to accident hazard would be omitted.

The applicant is questioned as to his habits, any family history of insanity or tuberculosis, his sight and hearing. He is asked if he has ever suffered from hernia, epilepsy, syphilis, vertigo, diabetes, mental disorders, or diseases of the heart, brain, nervous system, tonsils, nose, or throat. A record of medical attention received in the 2, 3, or 5 years preceding the date of application is commonly called for as well as a statement of the applicant's current physical condition.

The final section of the application is usually devoted to the executory agreements. These secure the applicant's assent that the insurance shall be subject to the policy provisions, that the contract is not effective until the application is approved and the policy issued or until the premium has been paid, and that the falsity of any representation shall bar recovery. The date and signatures of the applicant and agent complete the proposal.

Some applications are more complex than the one outlined, some less so. The above, however, represents the usual practice. It should be filled out by the insured, or in his presence by the agent, and signed by him.

Upon acceptance by the company, a copy of the application is specifically made a part of the policy contract. Either a photostatic copy is attached or a duplicate of the application is written into the policy. Usually the copy is appended at the end of the document although at least one company incorporates the application in the face of the contract. As part of the policy, the

insured has his statements before him where he can check them for mistakes. No agent or officer has the power to alter the application in any way without the written consent of the applicant. A few companies secure the consent of the applicant in advance to certain changes by including the following question in the application: "Do you hereby authorize the company to make such alteration in this application as may correct any spelling therein, or to correct any other apparent error or omission, and do you agree that your acceptance of such policy shall ratify such alterations?"

The Consideration Clause.—For many years, it was a nearly uniform practice to begin the policy with a statement of the *consideration*. The usual form was: "The Blank Insurance Company of Philadelphia (herein called the Company) IN CONSIDERATION of the statements in the application herofor, a copy of which application is endorsed hereon and made a part of this contract, and the payment of the premium of X dollars . . ." Some companies now include a statement of the consideration in the miscellaneous provisions. The statements in the application are made a part of the consideration, and it is upon the strength of these statements that the insurance is granted. Falsity of material representations will mean a failure of consideration and defeat the contract. It should be noted further that the premium itself is not part of the consideration; rather, it is the payment of the premium which is important. Accordingly, the premium must be paid before there is any coverage.

The Insuring Clause.—Probably the most important single clause in the entire contract is the *insuring clause*. It has been the subject of a great deal of litigation, but even yet the companies experience some difficulty in conveying through it the true intent of the policy. The following insuring clauses in the order given are typical of the *commercial*, *semicommercial*, and *industrial* types of policies, respectively:

The company hereby insures John Doe, subject to the provisions and limitations herein contained, against loss resulting directly and independently of all other causes from bodily injuries sustained during the term of this policy and effected solely through accidental means, and against loss resulting directly and independently of all other causes from diseases contracted during the term of this policy.

disability or loss as enumerated and defined in the contract is the company subject to liability.

Proximate Cause.—Loss must result “directly and independently of all other causes.” This clause is important in excluding from the coverage cases where preexisting disease (in case of accident) or abnormality is a contributing factor. The question is one of proximate cause in that the event must be the sole original cause of an unbroken chain of events bringing about a loss covered by the contract. If there is an abnormality or disease existing at the time of and contributing to the accident, the insured would not have a proper claim under an accident policy. For example, a person with an impaired heart might succumb because of a slight accident which would be of no consequence to a person in normal condition. Here the death would not have been effected by the immediate injury independently of all other causes.

Accidental Means.—The loss must result from “bodily injuries effected solely through accidental means” or as the result of disease. Considerable confusion has arisen among policyholders, claimants, and courts in recognizing the necessary distinction between accidental means causing injuries and injuries which are merely unforeseen results of means not accidental; or between effects due to and conditions merely subsequent to an accidental occurrence. Such a distinction is necessary to the very existence of accident insurance. The company grants indemnity for loss resulting from accidental means. If it were not to differentiate between the result and the means, the policy would be rightly construed to cover all death, sickness, and accident. Accident insurance at best is necessarily a limited form of insurance. It insures against death but not all deaths, against disability but not all disabilities. If it were to be construed to comprehend all such contingencies, it would be not accident insurance alone but life and health insurance as well.

“Death is brought about in an infinite number of ways. The insuring clause of an accident policy attempts in a few lines to limit liability to a fraction of that infinite number.”¹ It is therefore indispensable that the insuring clause be drawn without ambiguity. Accident policies have been drawn in many different

¹ CORNELIUS, MARTIN P., “Accidental Means,” pp. 1 ff.

ways, under varying circumstances and to meet a variety of conditions; and, in view of the difficulty of stating in general terms the nature of the hazard contemplated, it is not surprising that no little confusion and misunderstanding have arisen over the insuring clause. Early underwriters did not appreciate the complexity of the hazard with which they were dealing, with the result that the first insuring clauses were loosely drawn, in one case even agreeing to pay the death benefit "in case of death resulting . . . in consequence of accident."¹

Webster defines "accident" in the popular sense as "an event that takes place without one's foresight or expectation; an undesigned, sudden, and unexpected event; . . . chance; contingency. . . ." It is not surprising in the light of this definition that the companies with "wide-open" insuring clauses soon found that their policies were being construed to cover all fortuitous and unexpected bodily injuries, defects, or lesions and many of the changes in a person's health brought about by disease. All these conditions are "accidents" within the ordinary usage of the term. To protect themselves from liability for accidental results from voluntary acts performed as intended, the companies inserted a further qualification in the insuring clause stating that in addition to being violent and external the means must be accidental. In other words, the policy came to require that the means producing the result as well as the result itself must be accidental.²

Judge Dyer, in the leading case of *Barry v. U.S. Mutual Accident Association*, wrote:³

The term accidental is used in its ordinary popular sense and in that sense means "happening by chance; unexpectedly taking place; not according to the usual course of things; or not as expected." In other words if the result is such as follows from ordinary means voluntarily employed in a not unusual or unexpected way, then, I suppose, it cannot be called a result effected by accidental means. But if in the act which precedes the injury something unforeseen, unexpected, unusual occurs

¹ *North American Life and Accident Insurance Company v. Burroughs*, 69 Pa. State 43 (1871).

² CORNELIUS, *op. cit.*, p. 5.

³ 23 Fed. 712; affirmed 131 U.S. 100 (1889).

which produces the injury, then the injury has resulted from accident or through accidental means. . . .

R. W. Cooley comments:¹

Whether or not the means is accidental is determined by the character of its effects. Accidental means are those which produce effects which are not their natural or probable consequences. The natural consequence of a means used is the consequence which ordinarily follows from its use—the result which may be reasonably anticipated from its use, and which ought to be expected—the probable consequence which is more likely to follow than it is to fail to follow. An effect which is a natural and probable consequence of an act or course of action is not an accident nor is it produced by accidental means. It is either the result of actual design or it falls under the maxim that every man must be held to intend the natural and probable consequence of his deeds. On the other hand an effect which is not the natural or probable consequence of the means which produced it, an effect which does not ordinarily follow and cannot be reasonably anticipated from the use of such means, an effect which the actor did not intend to produce and which he cannot be charged with the design of producing, is produced by accidental means. It is produced by a means which was neither designed nor calculated to cause it.

Some courts have held that accidental means, in a narrow sense, can be present only in the occurrence of an event without human agency.² Practically, however, this restriction is too severe and is not followed in company practice,³ nor is it supported by the weight of authority in the courts.

From the doctrine enunciated by the U.S. Supreme Court in *Barry v. U.S. Mutual Accident Association*, cited above, certain corollaries may be derived. Specifically, it follows that there can be no recovery under a policy insuring against injuries effected through accidental means where such injury results from the voluntary act of the insured executed in the expected and ordinary way. Thus, death from the voluntary inhalation of oxide gas for the removal of a tooth or death due to a ruptured blood vessel following heavy exertion in pulling an automobile

¹ COOLEY, R. W., "Briefs on the Law of Insurance," Vol. VI, p. 5234.

² *Grosvenor v. Fidelity and Casualty Company*, 102 Neb. 629, 168 N.W. 599 (1918).

³ CROBAUGH, CLYDE J., "Handbook of Insurance," p. 12.

out of the mud would not be covered by accident-insurance policies insuring against the results of injuries effected through accidental means. If the policies, on the other hand, had simply provided indemnity in case of "death resulting in consequence of accident," the cases cited would have been proper claims.

If the insured does something which he intends to do but involuntarily does that thing in a way different from the way he intends and injury results, it is through accidental means. It is the ruling opinion that, unless the policy contains the statement that injury must result "solely and independently of all other causes" through accidental means, an insured who, overcome by bodily weakness or disease, falls beneath an approaching vehicle or sustains other injuries is covered under any accident policy. The "solely-and-independently" clause rules out injuries in which cooperating conditions are partly responsible for the accidental result.

It is essential that the true field of accident insurance be defined. Accident insurance insures against injury by the violent interposition of fortuitous events. An accident is an event—something that happens which is unforeseen, unintended, and unexpected by the injured person and which by its happening produces the force causing the injury. There is a series of occurrences: (1) the accident, (2) a violent force set in motion by the accident, (3) bodily injury caused by the violent force without concurring causes or cooperative conditions.¹

An example may serve to clarify the difference between injury, the unforeseen result of means not accidental, and accidental means causing injury. If, in climbing a stairs, a man should pull a muscle in his leg, being thus caused to fall and fracture an arm, the injury would not be the result of accidental means. He did everything as he had intended to do, and no fortuitous circumstance intervened to set in motion a violent force which would be the proximate cause of the accident. Suppose, however, that in climbing the stairs the man had slipped, pulled the muscle, fallen, and injured his arm. The slip, an unexpected, fortuitous event, was the accidental means initiating the chain of events resulting in the injury.

¹ LAMONT, STEWART M., "The Contract of Personal Accident and Health Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. XVIII, p. 51.

Although the U.S. Supreme Court has definitely defined accidental means and has distinguished the difference between injury which is the result of accidental means and the unforeseen or accidental results of means not accidental, the courts are by no means one in applying this doctrine. To cite but one example, it has been held that a person submitting to a surgical operation and dying therefrom did not succumb through accidental means.¹ The exact contrary has been the finding on essential similar facts in other cases.² In spite of the best efforts of the underwriters, "There have been accumulated such a number and variety of differing and apparently conflicting interpretations in various jurisdictions that our insuring clause, considered by itself, promises to become more or less esoteric and consequently more cordially to invite the application of the doctrine of ambiguity."³ It is perhaps not surprising that considerable uncertainty still prevails as to the conception of accidental means. The term "accident" engenders a variety of wide and vague fears in the public mind hardly susceptible of scientific definition. Courts are moved to stretch the policy phraseology to include as many of these border-line cases as possible. Considerations of public policy and private want have unquestionably influenced judges and juries, leaving some students of the subject with the impression that "accidental means" is a term not capable of exact definition. Certain it is that the courts have not lacked ingenuity in bending the clause to cover all manner of situations never contemplated by the companies.

Fortunately, the portion of the insuring clause dealing with sickness does not labor under the same difficulties as that applying to accidents. It is a simple statement that the policy insures against loss due to disease. The decision as to what is disease must remain in the hands of the physicians and the courts, for no clearer wording of the intent of the policy seems possible. Roughly any abnormal physical condition which is not caused solely by accidental means is classified as a disease. In policies

¹ *Pope v. Prudential Insurance Company*, 25 Fed. (2d) 596 (1928).

² *Belie v. Travelers Protective Association*, 135 S.W. 497 (1911); *Bailey v. Interstate Casualty Company*, 158 N.Y. 723 (1896).

³ LAMONT, STEWART M., "Constructing and Construing Policy Contracts," p. 3.

covering only sickness, some difficulty arises owing to efforts of insureds to make claims for disabilities resulting from accidental means. It is always provided in such policies that injuries effected by accidental means are excluded from the coverage.

Term of the Policy.—The insuring clause provides that the injuries must be sustained or the disease contracted during the term of the policy. The insurance can be granted only for the term for which the premium is paid. The provision also serves to exclude illness which antedates the policy, it being the presumption that the insured was in sound health at the date of issue of the policy. Were the company to cover all sickness suffered during the term of the contract regardless of origin, it would be subject to much adverse selection on the part of those recently exposed to disease. Since the contract indemnifies the insured only for injuries sustained or sickness contracted during the term of the policy, it is important that the period for which insurance is granted be stated definitely. This is done in a clause entitled "Effective Date and Term," found either on the face of the policy or among the "Additional Provisions." A typical clause states:

The term of this policy is . . . months from the . . . day . . . 19 . . . beginning and ending at 12 o'clock noon, Standard Time, of the place where the Insured resides.

For combination accident and sickness policies the following is a typical clause:

This policy is immediately effective as against loss due to such injuries at noon standard time at the place of the insured's residence, on the . . . day of . . . 19 . . . and shall become effective as against total disability the result of such sickness as may be contracted more than fifteen days after such date. The insurance granted hereunder shall terminate at noon, standard time, at the place of the insured's residence . . . day of . . . 19 . . . unless the policy be renewed from term to term by the payment in advance of an annual, semi-annual, or quarterly premium and by its acceptance by the company.

Some question has arisen about the extent of the company's liability for injuries sustained between the time that the agent takes the application and the policy is issued. Although the majority of courts still hold that the applicant has no right of

action until the application has been approved and the policy issued, there seems to be a trend toward permitting recovery. Damages are allowed against the company on the theory that, since the companies operate under state supervision, they are affected with a public interest and therefore have a legal duty which does not exist in the case of ordinary contracts.¹

The insurance is subject to the provisions and limitations contained in the policy. The insuring clause sets forth the general scope of the policy. It is amplified and limited by the provisions which follow.

The Benefits.—The insuring clause is customarily followed by a statement of the benefits provided in the policy. The *death and dismemberment* benefits payable in case of fatality or certain major losses through accidental means are usually set out first. One policy provides that

If such injuries shall cause continuous total disability as defined hereafter, commencing within 20 days from the date of accident, and during the period of such continuous disability, but within 200 weeks from the date of accident shall result, directly and independently of all other causes, in any one of the losses enumerated in this part, or within 90 days from the date of accident irrespective of total disability shall result in like manner in any one of such losses, the company will pay the sum set opposite such loss and in addition weekly indemnity as provided hereafter, to the date of death, dismemberment, or loss of sight, but only one of the amounts so specified and such additional weekly indemnity will be paid for injuries resulting from one accident.

The following schedule is then appended:

For loss of:

Life.....	The principal sum
Both hands or both feet—a sum equal to weekly indemnity for.....	200 weeks
Sight of both eyes.....	200 weeks
One hand and one foot.....	200 weeks
One hand and sight of one eye.....	200 weeks
One foot and sight of one eye.....	200 weeks
One hand.....	100 weeks
One foot.....	100 weeks
Sight of one eye.....	65 weeks
Thumb and index finger of either hand...	50 weeks

¹ WETTERLUND, R. J., "Effective Date," p. 4.

Payment of any such indemnity automatically terminates the insurance. "Loss" in this clause is specified to mean actual severance at or through a definite point or the entire and irrecoverable loss of sight, lest temporary blindness or loss of use of a limb might be claimed to have been covered. It is important to state that the specific loss must result from causes insured against, else the company might be held for death from natural causes.

Some companies are not so liberal as the company issuing the policy above and state that death or dismemberment must occur within 90 days of the accident to make the company liable for any sum over and above the weekly indemnity. Many companies set down the dismemberment benefits as a fraction of the principal sum rather than as a function of the weekly indemnity. The usual provision, in that case, is that the full principal sum will be paid for loss of life, sight, or two members, one-half the principal sum for the loss of hand or foot, and one-third this amount for loss of an eye. One company even grants one-quarter of the face of the policy for loss of speech and hearing. Certain commercial policies give the insured, in the event of the loss of both hands, both feet, or the sight of both eyes the option of electing to receive the weekly indemnity for total disability as long as he shall live, in lieu of the specific indemnity otherwise payable. There is little uniformity as regards the fractional amounts granted for the various dismemberments. The death and dismemberment provision is not included in health policies and may be excluded, wholly or in part, from an accident policy.

Some industrial policies carry a funeral benefit, usually \$50 or \$100. Others bind themselves to pay to the beneficiary the face of the policy within 24 hours after due proof of death has been furnished to the home office. Another clause, which originated as a talking point but is no longer used, provided a benefit to the insured of \$1,000 in the event of the accidental death of the beneficiary.

The death and dismemberment clause which well performs its true function is the first one outlined. It is liberal in that in the event of a prolonged total disability ultimately resulting in death or dismemberment the company will pay weekly indemnity during the time that the insured is attempting a recovery; then,

in the event that treatment fails, it will pay the principal sum or fraction thereof. While total disability is present, the company can watch the disability and is sure that where death or dismemberment results its cause dates back to the injury. If there is no period of disability, the company should not be expected to trace the course of the death or dismemberment back more than 90 days, and hence the limitation in such cases.

The Total-disability Clause.—As accident-and-health insurance is, above all else, earnings protection, it is designed to reimburse the insured for lost working time. Accordingly, the clauses providing indemnity for *disability* are of particular importance. We quote a typical accident-indemnity clause:

If such injuries shall not result as specified in Clause 1 (Death or Dismemberment) but, directly and independently of all other causes shall within two weeks from the date of accident, continuously and wholly disable and prevent the insured from performing any and every kind of duty pertaining to his occupation, the company will pay the insured the weekly indemnity above specified for the period of such total disability, not exceeding 52 weeks.

If such disability shall continue for the period of 52 weeks and if the insured shall then and thereafter be continuously and wholly disabled by such injuries, independently of all other causes, from engaging in any and every occupation or employment for wage or profit, the company will continue the payment of the weekly indemnity so long as the insured shall be so disabled.

This provision is typical of the most liberal practice. Two standards are incorporated for determining total disability. For the first 52 weeks, inability to perform the duties of the insured's occupation is total incapacity. After 52 weeks, a more stringent definition is applied. It would be impractical for the company to pay further indemnity if after 1 year's disability the insured is capable of engaging in any vocation. Take, for example, a dentist who has injured his hand so as to be unable to continue the practice of dentistry. The company will pay him indemnity for 1 year. By the expiration of 52 weeks, he may be sufficiently recovered to engage in a new profession such as real estate or insurance. He should be no longer entitled to indemnity. The double standard of definition seeks to prevent unfair claims by persons who though unable to resume their former

occupations are able to earn an income in some other field. The courts have not seen eye to eye with the companies in this matter however and in many jurisdictions have, by interpretation, practically wiped out the distinction between "his occupation" and "any occupation."

A clause representative of the quarterly-commercial policies provides:

If such injuries shall totally and continuously disable the insured within twenty days from the date of the accident, the company will pay the Insured indemnity at the rate of . . . dollars per month for the duration of such disability but for not more than twelve consecutive months.

A prominent industrial-accident insurance company provides:

If "such injury" alone shall from the date of the accident wholly and continuously disable the insured from performing any and every duty pertaining to his occupation the company will pay for the continuous period of total loss of time caused thereby indemnity at the rate of . . . dollars per month but not to exceed six consecutive months.

Some companies limit the weekly indemnity under any circumstances to 52 or 104 weeks. Others provide an additional lump-sum settlement if the insured is totally and permanently disabled at the end of the indemnity period. It is provided in certain contracts that disability to be covered must be immediate and continuous from the date of the accident. Others will cover disability originating as late as 20 days from the date of the accident. Few companies are willing to accept responsibility for disability which does not begin within 3 weeks of the date of the accident because of the difficulty of establishing the accident as the cause of the disability.

Many accident policies provide a schedule of elective indemnities which the insured may take in lieu of weekly indemnity for accidental injury. The amount allowed is a lump sum equal to the weekly indemnity which would be paid in the average claim for that particular type of disability. The insured must indicate to the company in writing within 20 days of the accident that he wishes to elect the lump-sum settlement lest the company suffer from an adverse selection. Such schedules of elective indem-

Part III.**Elective Indemnity—Accident Insurance**

The Insured, if he so elect in writing within twenty days from the date of accident, may take, in lieu of the weekly indemnity provided in Part II, indemnity in one sum according to the following Schedule if the injury is one set forth in said Schedule, but not more than one elective indemnity shall be paid for injuries resulting from one accident.

Schedule

If the single weekly indemnity for total disability payable under this Policy is Fifty Dollars the amounts named below shall be payable; if such weekly indemnity is greater or less than Fifty Dollars the amounts to be paid shall be increased or decreased proportionately.

For Loss by Removal:

Of one or more entire toes.....	\$400
Of one or more fingers (at least one entire phalanx).....	300

For Complete Fracture of Bones:

Skull, both tables.....	\$650
Thigh (shaft).....	600
Arm, between elbow and shoulder (shaft)...	600
Pelvis.....	500
Shoulder Blade.....	400
Leg (shaft).....	400
Knee Cap.....	400
Collar Bone.....	300
Forearm, between wrist and elbow (shaft)...	300
Foot (other than toes).....	250
Hand (other than fingers).....	250
Lower Jaw (alveolar process excepted).....	150
One or more ribs, fingers or toes.....	100

For Complete Dislocation of Joints:

Hip.....	600
Knee (patella excepted).....	300
Bone or Bones of Foot (other than toes)...	300
Ankle.....	300
Wrist.....	250
Elbow.....	200
Shoulder.....	150
One or more fingers or toes.....	50

A typical Elective Indemnity Clause.

nities offer definite advantages to both the insured and the company. To some policyholders, it is more satisfactory and convenient to settle a claim for an ordinary injury for a lump sum. Such settlements relieve the company of detailed investigation to determine the duration of disability.

Some companies require in their definition of total disability that the insured must be under the continuous and regular care of a legally qualified physician. Others specify that the physician must see the insured once every 7 days except in cases of bone fracture or convalescence from a major operation when one call in 2 weeks is deemed sufficient.

Exact definition of total disability has been difficult. Many policies contain a clause appended to the miscellaneous provisions restating that the company will recognize as total disability for the first 52 weeks only the absolute inability to perform any and every duty pertaining to the insured's occupation. After 52 weeks, indemnity will be paid if the insured is incapable of engaging in any work, vocation, or employment for gain or profit. Sometimes the definition "continuous and total loss of business time" is used. The U.S. Bureau of War Risk Insurance has employed a most liberal definition. It states total disability to be "any impairment of mind or body which makes it impossible for the insured to engage in a substantially gainful occupation."¹

The companies have been subject to the continual pressure of judicial liberalization of the meaning of "total disability." Indicative of the seeming distortion of plain words is the decision which defines total disability as "existing where a person no longer is able to do his customary tasks and such work as he is trained to do and upon which he must depend for a living." This definition was the judicial interpretation resorted to in allowing indemnity under a policy which provided benefits for total disability if the insured is "continuously prevented for life from engaging in any occupation or performing work for compensation of financial value."²

All provisions for weekly indemnity are subject to the limitations and exceptions expressed elsewhere in the policy.

¹ RIEGEL, ROBERT, and HARRY LOMAN, "Insurance Principles and Practices," p. 7.

² *Equitable Life Assurance Society v. Wray*, 262 N.W. 833 (1935).

Weekly or monthly indemnity is also provided under the sickness provisions of the policy. Typical clauses read:

If such disease, directly and independently of all other causes shall wholly and continuously disable the insured from performing any and every duty pertaining to his occupation, the company will pay beginning with the 15th day of disability weekly indemnity at the rate hereinbefore specified for the period of such continuous disability, but not exceeding 52 consecutive weeks. No payment shall be made for disability resulting from any disease for which the Insured is not treated by a physician, or for disease beginning within 14 days from the date of this policy nor shall indemnity be paid for the first 14 days of any period of disability.

The companies have found it necessary because of the somewhat greater hazard presented by sickness insurance to restrict the benefits more severely than for accident insurance. Only a very few offer life indemnity for illness in their commercial forms although indemnity for 104 weeks is not unusual. A waiting period of 7, 14, or 21 days is encouraged although much coverage from the beginning of disability is still sold. The requirement of medical attendance is uniform and necessary to prevent unjust claims and to facilitate recoveries. It is advisable to provide that the coverage shall not become effective until 2 or 3 weeks after date of issue in order that applicants who have been exposed to disease prior to receiving protection may not collect for any anticipated disability. This provision tends to curb adverse selection in health insurance. Some companies seek to attain this end by covering only "disease which is contracted while this insurance is in force."

Distinction between "total confining disability" and "total nonconfining disability" is quite common, as provided in the following clauses:

If such sickness totally and continuously disables and necessarily confines the insured strictly within doors, the company will pay the Insured indemnity at the rate of . . . dollars per month for the period of such confining total disability but not exceeding twelve consecutive months.

If such sickness totally and continuously disables but does not necessarily confine the insured strictly within doors, the Company will pay the Insured indemnity at the rate of . . . dollars per month for

the period of such non-confining total disability but not to exceed three consecutive months.

The full weekly indemnity rate is paid for confining total disability. A fraction of this rate is specified for the total non-confining disability. This type of disability should not be confused with partial disability. The insured is totally disabled but is not necessarily confined to the house. The maximum length of time for which indemnity will be paid for nonconfining total disability is usually 12 months. Some policies specify that it must follow total confining disability. Most companies regard the distinction between confining and nonconfining total disability resulting from sickness as a practical desideratum. From the insured's viewpoint, however, his wage loss is the same whether or not he is house confined. If he is not strictly confined, the medical expense may not be so heavy, for treatment may be received at the doctor's office. The lower rate of indemnity provided for nonconfining disability does serve to terminate some claims and makes possible coverage at a lower rate than if the distinction were not made. The nonconfining benefits are sometimes described as "convalescence indemnities."

A few health contracts make provision for permanent disability. In the event of total, irrecoverable loss of the sight of both eyes, or loss of use of two members because of disease, thus wholly and continuously disabling the insured from engaging in any occupation, the weekly indemnity will be paid for a total of 100 weeks. Such extended coverage is becoming more difficult to underwrite, owing to increasing adverse selection.

Partial Disability.—It is customary to include in the policy some provision for indemnity for partial disability. Usually, only partial disability resulting from an accident is covered. Owing to the difficulty of ascertaining any degree of disability resulting from disease, short of total disability, such indemnity is seldom granted in a health cover. A headache might partially disable the insured, but it would be difficult to establish any definite loss resulting therefrom. The purpose of the insurance is not to insure against pain or inconvenience but only to replace lost earning power.

Partial disability after accidents is usually indemnified in commercial policies at the rate of 40 per cent of the total-dis-

ability rate for a period limited to 26 weeks. There is a great lack of uniformity in practice relative to partial disability. The company's liability may extend from 10 to 52 weeks. The indemnity may range from 25 to 75 per cent of the total rate. Some carriers attempt to differentiate between degrees of partial disability, providing 75 per cent of the full rate for "intermediate partial disability," a condition preventing the insured from performing "the majority" of the duties of his occupation and 50 per cent of the full rate for partial disability which prevents the insured from "performing one or more important daily duties of his occupation." Such a provision is subject to such a variety of interpretations and manipulations that its use is not popular with most carriers. The whole idea of indemnity for partial disability is being much criticized. Recently a number of leading underwriters agreed to limit the benefit to 40 per cent of the total rate for 26 weeks. The majority of companies favor 3 months. Partial disability must originate within 20 days of the date of the accident or immediately follow a period of total disability.

One large insurer grants partial-disability indemnity for sickness, limiting the coverage to 50 per cent of the total rate for a period of 10 weeks. Continuous attendance by a physician is required, and no indemnity is granted for partial disability of less than 1 week's duration. This clause is a recognition that following severe illnesses there is a period of convalescence during which the insured's earning power is impaired. The clause is hedged about to prevent imposition because of mere indispositions. Many leaders in the business seriously question the value of partial-disability indemnity for sickness.

Double Indemnity.—Almost all contracts covering accidental injuries grant double or even triple or quadruple indemnity for disabilities incurred under certain circumstances. The benefit was added as a talking point. The public generally believes that there is some extra hazard involved in traveling. Herein lies the sales appeal of double indemnity. The companies have provided variously that the regular indemnity shall be doubled if the injuries are sustained:

1. While the insured is riding as a fare-paying passenger in or on any common carrier except aircraft,

2. While riding as a passenger in any regular passenger elevator.
3. In consequence of the burning of any building in which the insured shall be at the commencement of the fire.
4. By the explosion of a steam boiler.
5. By a hurricane or tornado.
6. By a stroke of lightning.

Loss due to injuries under such circumstances may be indemnified at triple the regular rate and injury due to accident in or on an automobile at double the regular rate. The gambling instinct of the prospect is appealed to by the provision for double indemnity. In spite of the fact that the clause is a valuable talking point, actual claims under it are not numerous. It is difficult to establish any economic justification for differentiating in the amount of indemnity payable for the same injury simply because it be received under different circumstances. One danger of including double-indemnity benefits is that the true purpose of the policy will be obscured and the insured will think in terms of the double benefit. Double-indemnity provisions flower most luxuriantly in the limited accident policies. For a very modest premium, under severely restricted circumstances the policies provide exceptionally large benefits which appeal to the "bargain hunter."

Hospital and Medical Benefits.—The benefits provided to reimburse the insured for the costs of hospital and medical care represent the greatest variety of practice. The group-hospitalization associations offer hospital coverage in the form of actual service. Insurance companies, on the other hand, offer cash indemnities. In accident-and-health policies, there are three distinct methods of providing this indemnity. The oldest provision contemplates a percentage increase in the amount of weekly or monthly total-disability benefit payable if the insured is confined to a hospital. A more recent development is the *unallocated medical-reimbursement clause* which undertakes to pay all the expenses of treatment for injuries up to a named sum. This clause applies only to accident insurance. Distinguished from it is the *allocated* type of coverage for both injury and sickness. The allocated reimbursement clause defines and enumerates the different kinds of expense covered, *viz.*, hospital room, surgical fees, and medical treatment, placing limits on the

amount of indemnity provided for each, whereas the unallocated type limits only the total liability of the carrier irrespective of the nature of the expense.

The medical-reimbursement clause is one of the most liberal benefits ever included in the policy. This provision has been incorporated in order that the policy may more nearly fulfill its mission as an indemnity form of insurance. The medical-reimbursement provision permits the weekly indemnity to play the part for which it was intended, *i.e.*, to replace lost earnings, whereas the extra benefit cares for the extraordinary expenses occasioned by the insured's disability. The following is one of the simplest and most liberal clauses:

If such injuries or disease, directly and independently of all other causes, shall require within 26 weeks of the date of the accident or sickness, medical or surgical treatment, hospital confinement, or the employment of a trained nurse, the company will pay, in addition to any other indemnity to which the insured may be entitled, the actual expenses of such treatment, hospital charges and nurses' fees up to an amount not exceeding the limit hereinbefore specified.

The insured may specify at the time the policy is issued the limit of medical reimbursement which he wishes. The usual limits are \$500 or \$1,000. The companies hope that by including such benefits the insured's recovery will be speeded by proper treatment and freedom from financial worry. The full-coverage clause quoted is by no means universal. Reimbursement for medical treatment on so wide a scale has been offered only since 1931. Only the larger underwriters have yet included the benefit in their contracts. Much of the success of the clause will depend upon the reception given it by the insured and his physician. If charges for medical service become excessive, the benefit will have to be withdrawn.

Although the benefit seldom extends to include expense due to sickness, the coverage has been sold extensively in combination with death and dismemberment benefits, as a separate policy, or as a supplement to the regular policies.

Whereas the unallocated clause was developed chiefly by the companies associated with the Bureau of Personal Accident and Health Underwriters, the allocated type of benefit was devised

and rated by the Health and Accident Underwriters Conference. It is an outgrowth of the older hospital-and-nurses clause. The protection offered by the allocated type of benefit is roughly similar in scope to a membership in a group-hospitalization plan with the essential difference that the insurance policy provides cash indemnity whereas the group-hospitalization plan furnishes the actual care. The allocated indemnities include provision for hospital-room rent of \$3 to \$5 per day; operating-room fee up to \$10; anesthesia up to \$5; X-ray examination up to \$5; and laboratory fees up to \$1.50. In addition a schedule of surgical-operation benefits is ordinarily included with the limits of reimbursement ranging from \$5 for simple suturing of wounds to \$75 or more for abdominal surgery. It is customary in connection with sickness losses to provide that the hospital and surgical benefits shall be effective only as against such sickness as may be contracted more than 60 days after the date the policy is issued. One company even provides that the surgical benefits shall not apply until the policy has been in force for 6 months. These provisions are inserted for the purpose of reducing the moral hazard. The clause ordinarily states that the hospital or surgical care must be recommended by a qualified physician or surgeon. No more than the maximum amounts stated in the policy will be paid for any one disability or in any one 12-month period.

Both the allocated and the unallocated hospital-benefit clauses approach the problem of indemnifying the costs of disability from the standpoint of what the average cost really is. They attempt to relate the benefit to the actual expense. This approach is altogether different from that of the older type of hospital benefit which has commonly been included in accident-and-health-insurance policies for many years. The older form is simply a 50 or 100 per cent increase in the weekly or monthly total-disability indemnity if the insured be confined to a hospital or requires the attendance of a graduate nurse. This indemnity is often supplemented by a schedule of surgical-operation benefits payable in addition to the other indemnities if the insured is forced to submit to a surgical operation within 90 days of the inception of disability. Although this form does provide substantial coverage, it is open to the serious practical objection that the amount of weekly indemnity provided by an insured's

policy is no gauge of his probable hospital and surgical expense. Within fairly definite limits, the hospital expenses of big and small policyholders will run about the same. Even a policy providing total disability benefits of \$100 per month with a 50 per cent increase for hospital confinement will give the insured only \$1.67 a day additional to cover his hospital costs. It would seem that the allocated and unallocated forms offer much more adequate protection than the older clauses.

Some companies have expanded the allocated form to include reimbursement for medical service on the basis of \$3 or \$5 per call with a limit on the total number of calls for which indemnity will be paid. Others make a like provision to cover the expense of a graduate nurse for a limited period. Reimbursement of the insured for physicians' fees is not common, however, except under the unallocated medical reimbursement for injuries.

The provisions designed to relieve the policyholder of the costs of medical care afford true indemnity. Many clauses provide that the benefit is payable if the insured is a "patient paying personally" for treatment; or the policy may stipulate that "the Company will reimburse the insured for sums actually expended by him" for specified care. This point has a particular bearing on certain classes of risks who are entitled to hospitalization without charge such as war veterans, employees of railroads and of large industrial enterprises which maintain company hospitals for their care, and persons receiving medical benefits under state workmen's-compensation laws.

Many policies contain a provision affording indemnity up to a limit of \$10 to cover medical expense or first-aid treatment in the event of nonfatal and nondisabling injury. Such a provision though a good selling point is intended only to reimburse the insured for treatment of trifling injuries and effects very little real earnings protection.

The medical provisions of the policy exhibit the greatest variety of practice. Many companies do not attempt to offer any indemnity at all to cover such expense.

Identification Clause.—One of the clauses which is very nearly always included in both accident and health policies, but which is of little practical significance, provides that if the insured be disabled while away from home and unable to communicate with

friends, the carrier upon receipt of a telegram or other message will immediately transmit to relatives or friends any information respecting him and will defray the expense necessary to put the insured in care of friends within a limit of \$100. The clause is intended to be a service rather than a benefit feature. As such it has a certain sales value, but many carriers have never been called upon to render the service provided.

Miscellaneous Benefit Provisions.—In addition to the death, dismemberment, total- and partial-disability, medical-reimbursement, and identification benefits, which are included with fair uniformity in most full-coverage policies, there are a number of other benefits which the company may include if it sees fit. Some are mere frills, having only sales appeal; others perform worthwhile services.

Indemnity for time lost due to quarantine is a common inclusion in policies covering sickness. If the insured is quarantined in his home by a legally constituted authority, indemnity will be paid for a period ranging from 6 weeks to 3 months either at the confining or at the nonconfining total-disability rate.

Some contracts provide that if the insured shall suffer the total and irrecoverable loss of his sight owing to disease or become paralyzed in two members and shall survive the 52-week period during which the company pays weekly indemnity, then he shall be entitled to receive a lump-sum final settlement in an amount equal to total-disability indemnity for 100 weeks. There must be reasonable proof that the disability will be permanent.

One large insurer provides an annuity of \$80 per year per \$1,000 of principal sum insured if the policyholder be totally and permanently disabled continuously from the date of the accident or illness and for more than the period for which weekly indemnity is provided. Such benefit is granted in lieu of payment under the dismemberment clause. The annuity is paid annually to age 65.

A cash-advance provision is included in one policy. It provides that upon receipt of due proof of disability accompanied by an order of the insured, the company will advance to any hospital, physician, or surgeon a sum sufficient to insure proper attention but in no case exceeding \$250.

The actual expense of X-ray pictures taken in effecting a diagnosis, but not exceeding an amount equal to one-half the

regular weekly indemnity, is covered in one policy. Another contract especially designed for women allows indemnity for 1 month, at 50 per cent the full rate, for disability due to normal childbirth after the policy has been continuously in force for a period of 10 months. Most policies specifically exclude loss of time from this cause from the coverage.

Waiver of premium in the event of total-and-permanent disability is frequently included. Some companies, on the other hand, deduct any premiums which fall due during the insured's disability from the indemnity due him.

A "legacy supplement" has been made available to its policyholders by one large insurer. For an extra premium, the company will pay the beneficiary an annuity of \$50 per month with 100 months certain in addition to the principal sum of the policy, if the insured die through accidental means. The life-insurance principle that settlement of the policy proceeds in a lump sum is not to the beneficiary's advantage is gaining a wider acceptance in accident insurance. Many policies now provide for the payment of principal-sum benefits over a period of time.

The infinite variation possible in the benefits provided under the policies now issued inhibits a complete discussion of all of them. The foregoing, however, cover the most important of the miscellaneous benefits.

The Accumulation Clause.—One of the devices which was introduced into the policy about 1900 in an effort to reduce lapsation was the *accumulation clause*. Its ends were defeated when a special fully accumulated policy came out. In spite of the fact that the clause is contrary to some of the prime principles of underwriting, it is still found in many policies.

A typical clause provides that:

Each consecutive renewal of this policy without default in payment of premium when due, will add 10% to each of the original sums as stated heretofore until such additions shall amount to 50% of such original sums; and thenceforth so long as this policy shall be continuously maintained in force without lapse by the payment of annual premiums in advance of the renewal date, the insurance will be for such original sums plus such accumulations.

Monthly-premium policies provide a 1 per cent increase per month for each consecutive renewal, subject to a limitation of

50 per cent. In some policies, the annual increase is 5 per cent rather than 10 per cent.

Quarterly-commercial policies sometimes incorporate a provision which is calculated to prevent lapsation by decreasing the premium rather than increasing the benefits if four quarterly premiums are paid in advance. One such policy provides a flat \$2 reduction in such case.

One company incorporates an accumulation clause which undertakes to triple the accidental death benefit in the policy over a period of 20 years if during that time the policy is maintained continuously in force by the payment of an annual premium. After 20 such annual payments have been made, the fully accumulated benefit will be continued in force for an additional annual premium of \$5. Somewhat similar in purpose is the "merit-rating clause" found in some policies. It provides for either a decrease in premium or an increase in indemnities in the event no claims are filed and the policy is maintained continuously in force for a certain number of years or months.

The Grace Period.—Some policies provide that the insured is entitled to a *grace period* without interest for the payment of every premium after the first. Industrial policies calling for monthly premiums may grant a shorter grace period (varying from 3 to 10 days) than the commercial annual-premium policies which allow 30 days.

A recent general survey conducted by the Health and Accident Underwriters Conference indicates that only about one-third of the companies writing commercial business grant a grace period. The period varies from 5 to 30 days. On the other hand, practically all companies issuing monthly industrial policies use a grace period in their forms. The usual stipulation is, however, that the policies shall have been in force a given number of months (often 3 months) before such grace period is effective. The clause has been incorporated mainly as the result of competitive practice, and many companies object to it as giving "free insurance."

The Incontestable Clause.—Some companies waive the right to contest any claim on the basis of misstatement in the application after the coverage has been in force for a period of 2 to 5 years. The policy becomes *incontestable* as to the physical con-

dition of the assured or the materiality of any representation contained in the application. This is a desirable provision; and if a sufficient period is allowed to elapse before it becomes operative, the company should not be subject to any particular difficulty because of the fraudulent misstatement of the insured's condition or previous history.

Mutual Participation.—The Metropolitan Life Insurance Company of New York created something of a sensation in accident-and-health-insurance circles when it included a provision in its contracts calling for dividends on its disability policies. As most mutual companies granting accident-and-health protection operate on an assessment basis, keeping the assessments down nearly to the actual cost of the coverage, few of these associations have had occasion to divide any apportionable surplus. A few mutuals, operating like life-insurance companies upon a stipulated-premium plan, could declare and have declared dividends on their policies. Such a participation clause reads:

This policy is a participating contract, and commencing not later than the third policy year, the company will annually, if and while this policy is in force, ascertain and apportion any divisible surplus accruing hereon, after setting aside such an amount for a contingency reserve as the directors of the company shall deem necessary.

Mutual policies unless issued upon the stipulated-premium basis uniformly contain an assessment provision. The insured is notified that as a policyholder he is a member of the association entitled to a vote at annual and special meetings. The contingent liability of the insured is usually limited by law to 1 year from the expiration or cancellation of the policy and shall not exceed an amount equal to and in addition to the premium stated in the policy. Some forms do not limit the amount of additional assessment, saying simply that if the premium is insufficient the association may call for the difference, but more often the contingent liability is stated to be an amount not exceeding the annual premium or a fraction thereof.

One participating contract provides for a dividend in the form of extended insurance. For 5 consecutive years' maintenance in force, the insured is entitled to 3 months' extended insurance; for 10 consecutive years', 6 months' extended insurance; and for

15 years', 12 months' extended insurance. In addition, a cash dividend is provided. If before the insured has attained 70 years of age he has maintained the insurance continuously in force for 20 years, the company will pay a final cash dividend equal to 50 per cent of all premiums paid in less the total amount allowed on claims and for extended insurance.

Additional Provisions.—Under the head of *additional provisions* the company sets forth excepted disabilities and conditions and further defines the coverage. Formerly, it was the practice of too many companies to grant extremely liberal benefits on the face of the policy only to hedge these about with all manner of limitations in the additional provisions. It is to the credit of the business that these restrictions are becoming fewer and simpler. The Standard Provisions Law permits the companies to use the additional provisions to define any words used in the policy, to exclude (in boldface type of the same prominence as the benefits) certain hazards, and to include miscellaneous provisions bearing upon renewal of the contract or assignment of it.¹ Uniform practice excludes from the accident portion of the policy death or disability caused wholly or in part by: (1) bodily or mental infirmity, (2) bacterial infections (except pyogenic infections arising out of an accidental wound), (3) any kind of disease, (4) medical or surgical treatment (except as made necessary by the covered injury), (5) any act of war or suffered while the insured is engaged in military or naval service in time of war. Nor shall it cover (6) any bodily injury which shall result in hernia, (7) any injury sustained by the insured while in or on any aerial device or submarine, (8) suicide or any attempt thereat while sane or insane. Restrictions on the sickness indemnity include the following: (1) The disease must be contracted during the term of the policy, (2) while the insured is in the United States or Canada south of the 60° of north latitude, and (3) diseases contracted during military service in time of war and bodily injuries effected through accidental means are excluded.

These are the bare minimum of limitations imposed by present-day practice. Usually the company will endorse the policy without extra premium permitting the insured to ride as a fare-paying passenger on regular commercial air lines between defi-

¹ SOPER, L. P., "Study Outline of Accident and Health Insurance," p. 22.

nately established terminals. In most cases, there is no reduction of indemnity in event of accident under such circumstances, but some companies cut the benefits 50 per cent.

The additional provisions will reflect in a large measure the purpose for which the policy is intended and the amount of premium paid. No one type of policy could possibly meet the requirements of all insureds. No one premium would be satisfactory in every case. Partly through the additional provisions, the insurer is able to mold its different policy forms to fit the different types of requirements. Industrial policies which are sold for a few cents a week contain considerably more restrictions than the commercial forms.

Of the many other restrictions which are incorporated in the contracts, only a few are worthy of note. Injury or sickness from the following causes or under the following circumstances may serve to reduce or vitiate indemnity entirely: (1) while racing, fighting, or speeding; (2) while violating the law; (3) while under the influence of intoxicants or narcotics; (4) while riding on a motorcycle; (5) while practicing or playing football or polo or engaging in professional or semiprofessional sports, (6) if caused in whole or in part by dementia, embolism, sunstroke, heat exhaustion, freezing, gas, prostration, neuritis, paralysis, pneumonia, cancer, tuberculosis, lumbago, sprained back, (7) if leaving no visible mark or contusion (except in drowning), (8) if affecting organs not common to both sexes, (9) if intentionally inflicted upon the insured by any person (assault by highwayman or burglar excepted), or (10) if sustained while the insured is willfully violating any law or is engaged in riot or insurrection. Syphilis and venereal disease and the effects thereof, insanity and paralysis, are the most common exclusions in less-than-full-coverage sickness policies.

It is customary to provide for an increase in premium or a corresponding reduction in benefits at age 50 and again at age 60. The age limit is stated in the policy, usually 60 years for health, and 65 or 70 for accident. When the insured attains these ages, the coverage expires.

An unusual provision of one policy is that the payment of benefits shall be subject to limitation by the earnings of the insured. Regardless of the benefits provided, no indemnity in

excess of the average earnings enjoyed by the policyholder is payable.

Another contract for a nonoccupational-accident policy excludes payment of indemnity on any injury for which the insured is receiving benefits under a workmen's-compensation law.

The vast number of suspicious claims which have arisen from the inhalation of carbon monoxide gas by the insured is responsible for a fairly common provision that if the insured die by the unconscious or involuntary inhalation of gas or poisonous vapor the company's liability shall be limited to 25 per cent of the principal sum insured.

The arbitration clause is little used in accident-and-health-insurance. One large insurer, however, does provide that: "In the event of dispute arising as to claim under this policy, such dispute may, by mutual consent, be referred to three impartial arbitrators, one to be named by the company, one by the insured, and the other to be chosen by the two named. Any adjustments so made at that time in writing shall be final."

The adoption of the arbitration technique for settling disputes is receiving more serious consideration than heretofore as the slow, wasteful, and unsatisfactory nature of lawsuits makes itself more apparent. All companies are anxious to reduce the delay and expense connected with litigation, but considerable question exists whether or not the insured can be forced to refer a claim to arbitration.

The beneficiary may be changed under an accident policy if the insured so requests the company in writing. No assignment of the policy or any claim thereunder is binding upon the company until accepted at the home office by an officer of the company. The policy may be renewed, subject to all its provisions, from term to term with the consent of the company by payment of the premium in advance. Reinstatement is subject to the various rules employed by the companies but usually can be effected with the company's consent by the payment of a premium in advance. Evidence of insurability is sometimes required. One of the most common provisions is to the effect that any failure to comply with the policy provisions will forfeit all right to indemnity.

The Standard Provisions.—Nearly all accident-and-health-insurance policies except fraternal-benefit certificates contain the *Standard Provisions*. Massachusetts, Oregon, and Idaho, in 1911, were the first states to make the inclusion of these provisions mandatory. Standard Provisions laws have been enacted in 24 states including Connecticut, Illinois, and New York. The exact wording of the provisions is prescribed in the law and must be followed in the policy form. The Standard Provisions laws of the several states are essentially similar, but slight differences in wording have crept into the statutes. The requirement that the policy form follow the law exactly in each state makes for an annoying and expensive situation for the carriers, for several different policy forms must be prepared to give effect to the minute variations among the states. Policies containing the Standard Provisions are quite uniformly acceptable to the insurance departments in states which have not passed the Standard Provisions Law.

The purpose of the Standard Provisions is to set up simple, fair, and uniform operating conditions for the contract. Before the enactment of these laws, each company had its own rules for presenting notice of claim, filing proofs of loss, and reinstating the contract in case of lapse. In some instances, the requirements, which were made conditions precedent to recovery, were most severe. In order to avoid confusion and assure provisions fair to both the insured and the insurer, the legislatures of the several states, encouraged by the more farsighted leaders of the business, laid down in these laws the manner in which routine procedures common to nearly all policies should be handled.

The first 15 of the Standard Provisions are mandatory. The inclusion of the last 5 is optional with the company. But if the policy contains any clause bearing upon the matters covered by the optional Standard Provisions, the wording of the statute must be used.

Standard Provision 1 may be included in either of two different forms.¹ The first form is for use in policies which do not provide for a reduction of indemnity on account of change in occupation.

¹ The Standard Provisions provided by the insurance laws of Connecticut have been used in this text as representative of the requirements of most states. See *State of Connecticut Insurance Laws, 1938, Secs. 4218-4221*.

The second form is for inclusion in policies which make such reductions. Both forms provide that the policy with attached papers or endorsements, if any, constitutes the entire contract. The first form states that no reduction shall be made in any indemnity on account of change in the insured's occupation. The other, or "prorating," form provides that the benefits payable may be modified if the insured is injured in a more hazardous occupation than that in which he was insured. In that event, the insurer will pay only such portion of the indemnities provided in the policy as the premium paid would have purchased at the rate but within the limits fixed by the insurer for such more hazardous occupation. The insurer is usually required to file its schedule of rates and classification of risks with insurance departments of the states in which it operates.

Standard Provision 2 controls changes in the policy. No change shall be valid unless endorsed upon the policy with the approval of an executive officer of the company. Agents may not make such changes. No statement by the applicant unless a part of the application and policy shall avoid the contract or be used in any legal proceeding thereunder.

Standard Provision 3 limits the effect of reinstatement of the policy after lapse. If the policy is an accident-only contract, acceptance of a premium by the company or its duly authorized agent shall reinstate the policy but only to cover injuries sustained thereafter. If the policy is a health-only contract, the reinstatement is effective only against such sickness as may begin more than 10 days (in some states, 15 days) after the date of reinstatement. In policies covering both accident and sickness, these two provisions are combined.

Standard Provision 4 states the length of time within which the insured must give notice of claim. Ordinarily, the insured is required to notify the insurer within 20 days of the date of an accident or within 10 days from the inception of disability due to sickness. Some states, however, allow the policyholder as much as 60 or 90 days to notify the insurer of disability. In accident policies, the insurer may, at its option, require immediate notice of accidental death.

Standard Provision 5 sets up standards of sufficiency of notice of claim. Any notice given to the insurer's home office or a duly

authorized agent with particulars sufficient to identify the insured is deemed sufficient. Failure to give notice within the time required by the policy will not invalidate a claim if it be shown that it was impossible to give notice within the required time and that notice was given as soon as was reasonably possible.

Standard Provision 6 requires the insurer to furnish the policyholder with claim-proof blanks within 15 days after receipt of notice of claim. If such forms are not so furnished, the policyholder is deemed to have complied with the provisions of the policy as to proof of loss if within the time limit fixed by the policy he files with the insurer written proof concerning the occurrence, character, and extent of the loss.

Standard Provision 7 sets a time limit for filing proofs of loss. Proof must be filed, in case of claim for loss of time, within 90 days after the termination of the period of disability for which the insurer would be liable. Claims other than for loss of time must be filed within 90 days after the date of such loss.

Standard Provision 8 gives the insurer the right to examine the person of the insured when and as often as it may reasonably require during the pendency of claim and the right to make an autopsy in case of death, where not forbidden by law.

Standard Provision 9 may be omitted from policies which provide indemnity only for loss of time due to disability. It stipulates that all indemnities other than for loss of time will be paid within 60 days of receipt of proof.

Standard Provision 10 need not be included in policies which do not contain benefits for loss of time. Upon the request of the insured, subject to due proof of loss, the insurer must pay at least 50 per cent of the accrued indemnity every 60 days during the continuance of the period for which it is liable, the balance remaining unpaid at the termination of such period being payable immediately upon receipt of due proof. The percentage of accrued indemnity and the time intervals at which it must be paid vary considerably. In some instances, all accrued benefits must be paid every 30 days.

Standard Provision 11 designates to whom the indemnities shall be paid. Indemnity for loss of life under accident policies shall be paid to the beneficiary, if surviving; if not surviving, to

the estate of the insured. All other benefits are payable to the insured.

Standard Provision 12 gives the insured the right to cancel the policy if he changes his occupation to one classified by the insurer as less hazardous than that stated in the policy and to receive from the insurer a return of the unearned premium.

Standard Provision 13 states that the consent of the beneficiary shall not be requisite to surrender or assignment of the policy, change of beneficiary, or any other change in the policy. Sick-ness-only policies and accident policies not providing a death benefit need not include this clause.

Standard Provision 14 limits the time within which suit may be brought on the policy. Suit cannot be instituted prior to the expiration of 60 days after proof of loss has been filed, nor can such suit be brought at all unless within 2 years (in some states, 5 years) after expiration of the time within which proof of loss is required by the policy.

Standard Provision 15 states that, if any time limitation of the policy with respect to giving notice of claim or filing proof of loss is less than that permitted by the law of the state in which the insured resides at the time the policy is issued, such limitation is extended to coincide with the minimum period permitted by such law.

The *optional* Standard Provisions begin with 16 which gives the insurer the right to cancel the policy at any time by written notice delivered to the insured or mailed to his last address as shown by the records of the insurer together with cash or the insurer's check for the unearned portions of the premiums actually paid by the insured. Such cancellation does not affect the insurer's liability for any claim originating prior thereto. Standard Provision 16 is omitted from noncancelable policies.

Standard Provision 17 permits the insurer to prorate the indemnity payable in the event the insured has secured other insurance covering the same risk without giving written notice to the insurer. If the policyholder holds such other insurance, the insurer is liable only for such portion of the indemnity promised as that indemnity bears to the total amount of like indemnity in all policies covering the loss. It must also return to the insured such part of the premium paid as shall exceed the

pro rata for the indemnity as above determined. This provision is frequently omitted from the policy.

Standard Provision 18 gives the insurer the right to deduct from the proceeds of any claim settlement any premium then due and unpaid or covered by any note or written order.

Standard Provision 19 permits the company to state in the policy that, if the insured holds any other policy or policies previously issued by the company and concurrently in force so that the aggregate amount of indemnity provided by all such policies exceeds a certain sum, the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured. This provision sets a maximum limit on the amount for which the company may become responsible for any one risk and is particularly valuable with the limited types of policies such as are issued through newspapers.

Standard Provision 20 sets out the age limits of the policy stating that the insurance under the policy shall not cover any person under the age of . . . years nor over the age of . . . years. Any premium paid for periods not covered by the policy will be returned upon request.

The Standard Provisions have been invaluable in bringing a greater degree of uniformity and fairness into the operation of the contract. They have made the policy more understandable to the general public. Their only serious flaw lies in the minor differences in phraseology which have crept into the statutes of the different states. The companies could effect a considerable saving if all states adopted exactly the same language.

Signature Clause.—The contract customarily closes with the signature clause. Some accident-and-health policies follow the pattern of those of the life companies, the signature clause being placed on the face of the policy and the material on succeeding pages being incorporated by reference. The policy usually carries the facsimile signatures of two executive officers and countersignature by an authorized agent or policy clerk.

CHAPTER V

TYPES OF POLICY CONTRACT

The preceding chapter dealt at some length with the typical accident-and-health-insurance policy. Significant characteristics of the commercial, quarterly-commercial, and industrial policies were pointed out. No study of the contracts issued by disability-insurance carriers would be complete, however, without some mention of the policy forms which depart widely from the typical coverage.

Industrial Policies.—The commercial type of policy is issued to persons engaged in the less hazardous pursuits, whereas the *industrial* forms are available to workers in occupations which carry a higher degree of exposure to occupational injury. The policies are essentially similar. The industrial policy is differentiated from the commercial form by the smaller indemnities provided and the option of more frequent premium payments. The monthly-premium forms contain all the usual commercial provisions and are issued on an occupational basis. The weekly-premium types are usually nonclassified forms and always include a small funeral benefit. The weekly-premium industrial policy besides being issued on a nonclassified basis requires bed confinement to entitle the insured to total-disability benefits. In recent years, the popularity of the weekly-premium forms has waned and that of the monthly-premium type has increased.

The desire for more extensive or cheaper protection has led to the organization of many fraternal, mutual-aid associations, and trade-union-benefit plans. Much of the ability of these groups to pay has depended upon their size and location and the loyalty of their members. The benefits of some corporate-benefit societies, as in the steel and rail trades, have been guaranteed by the corporation whose employees are covered.¹

¹ REIGEL, ROBERT, and HARRY LOMAN, "Insurance Principles and Practices," p. 5.

The better industrial policies, especially those issued by regular corporate insurers, offer splendid protection. They include benefits for loss of life, limb, and time and hospital, surgical, and nursing indemnities. The exceptions are no more stringent than in many of the commercial forms, and the indemnity is payable for nearly as long a period. One such policy provides indemnity for total disability due to accident for 3 years and in addition indemnity at 25 per cent of the full rate if the insured is totally and permanently disabled after the 3-year period. Although the indemnities provided are not so liberal as those of the more expensive commercial forms, industrial policies have performed a service of inestimable value in bringing the major benefits of accident-and-health insurance within the reach of the mass of people.

Special-risk Policies.—Although *special-risk* policies play a less important part in the field of earnings protection than the industrial or commercial forms, their function should not be overlooked. These contracts, sometimes termed *limited* policies, cover a specific hazard or hazards. They are not general accident or health policies which contain certain restrictions upon the full coverage.

The chief forms of special-risk policy are those covering railway- and aviation-travel accidents, the *newspaper* policies, and *automobile-accident* policies.

The *railway-travel* policy is the oldest and best-known type of special-risk policy. It is the direct lineal descendant of the old ticket policy issued by the Railway Passengers' Assurance Company and the Travelers Insurance Company. It is sold at all railway-ticket offices. The Aetna Life Insurance Company and Travelers Insurance Company are two of the biggest insurers of this type of risk. The contract though designed primarily to cover accidental death or disability while traveling has come to include practically full protection. The chief difference between the travel policy and general accident insurance is the length of time during which it is in force and the manner of its sale through ticket offices, hotels, garages, and filling stations. The policy is issued for periods which vary from 1 day to 120 days. The cost of the 1-day policy is 25 cents for \$5,000 death-and-dismemberment indemnity, \$25 weekly indemnity for total disability, and

\$12.50 per week for partial disability. Total indemnity is limited to 52 weeks, partial to 26 weeks.¹ The value of the policy is somewhat reduced because it does not cover disappearances, injuries leaving no visible wound or contusion, medical or surgical treatment, hernia, poisoning, sunstroke, freezing, suicide, injuries received while entering and leaving moving conveyances, etc.² The policy is not restricted necessarily to travel accidents. Some forms are issued with a face of \$2,500 and \$12.50 per week, and these indemnities are doubled in event of accident on a common carrier. In spite of the wide benefits, the coverage is relatively expensive. If the average policy is in force 30 hours, yearly protection would cost \$73, which is several times the premium for a good commercial policy.³ However, in view of the adverse selection (good physical condition is not required) to which the company is subjected and the extra-expense element in handling the cover, the rates do not appear unreasonable.

The *aviation-ticket* policy is in most respects similar to the railway-travel policy. It is sold at railway stations and airports and covers chiefly travel on regularly licensed air lines. The accident-insurance coverage available to air travelers, aviators, and students has kept pace with the development of the aviation industry and the increasingly favorable safety records achieved by the air lines. The two principal types of air risk with which accident underwriters are concerned are those of the passenger and of the pilot or others engaged in the business.

The coverage which is available to the fare-paying passenger is broad and inexpensive. Most of the regular commercial forms of accident policies now include coverage without extra charge if the insured sustains injuries

. . . while riding as a fare-paying passenger in a licensed passenger aircraft provided by an incorporated passenger carrier while operated by a licensed pilot upon a regular passenger route between definitely established airports; but otherwise this insurance shall not cover any loss sustained from being in or on, or about, or operating, or handling any vehicle or mechanical device for aerial navigation, or in falling or otherwise descending from or with such a device.

¹ KULP, C. A., "Casualty Insurance," p. 5.

² RIEGEL, ROBERT, and HARRY LOMAN, *op. cit.*, p. 3.

³ KNIGHT, C. K., "Advanced Life Insurance," p. 354.

For the person whose accident insurance does not extend to aviation injuries or who desires additional protection while flying, there is the aviation-ticket policy. Like the original railway-ticket policies, the single-trip aviation contracts were developed largely at the instigation of the transport managers. The air lines encouraged the development of the contract as an additional means of allaying the public's hesitancy over flying. The most liberal policy, introduced during 1937, covers only passengers traveling in airplanes of established air lines belonging to the Air Transport Association and operated under the supervision not only of the operating company and the government but of insurance inspectors and underwriters as well. The premium charged is 25 cents for each 4 hours of scheduled flying. The rate for the regular trip from New York to Chicago would be 25 cents; from New York to Los Angeles not to exceed \$1. The premium charge depends upon the length of the scheduled flight, not the actual number of hours flown. Interruptions due to delay or stopover do not affect the premium. The policy provides a death benefit of \$5,000 and dismemberment indemnities ranging from \$2,500 to \$5,000. The coverage extends to injuries sustained while on trains or steamships between certain points or in automobiles arranged for by the air lines for transportation to and from airports.¹

Accident insurance for the pilot and aviation student is somewhat more expensive. This type of cover is yet in its early development. A typical contract offered to private fliers covers, in addition to accidental death from the usual causes, death due to injuries sustained while riding as a passenger on an established air line or as a passenger or pilot in a licensed private airplane. This policy is issued for a 12 months' period only, subject to annual renewal. Indemnities of \$3,000 to \$10,000 are written at the rate of \$15 per \$1,000 per year. In all cases, the pilot of the airplane must hold a valid pilot's license; no trip of more than 300 continuous nautical miles over water is covered. The insurance does not cover death during or caused by: (1) any violation of a regulation of the Civil Aeronautics Authority; (2) any flying for hire or any purpose other than private pleasure or personal

¹ "Insurance Provided for Single Air Trips," *Weekly Underwriter*, Nov. 27, 1937, p. 1134.

transportation; (3) any acrobatic flying, stunt flying, racing, or hazard contests; (4) any flying outside the Continental United States; (5) any flying in a newly constructed airplane until it has made successfully a complete circuit in the air and a landing without accident; (6) any taking off or landing in a place other than an established airport or space of land or water suitable as to size, condition, and surrounding objects for safe landing or taking off, forced landings alone being excepted; (7) any flying at night more than 50 miles from a lighted airway. The findings of the Civil Aeronautics Authority are made final for the determination of the facts of any airplane accident.

Another type of coverage given to aviation accidents is the *airsurance* policy issued through an underwriting syndicate of casualty companies. Strictly, this is not personal-accident insurance but takes the form of an *employers'-voluntary-contractual-liability* policy. It was developed at the request of large employers who were seeking insurance as an additional means of encouraging their executives and employees to save time by the use of air travel. Technically, the policy indemnifies the employer in the event of the employee's death due to injuries received during a transport flight. Indemnity is offered up to \$10,000 per individual named in the policy. The charge is \$1 per year per \$1,000 per person with a minimum premium of \$50 covering five or more persons.¹

Newspaper Policies.—The *newspaper policy* is of comparatively recent origin. It has attained wider significance and development in England where it has been especially popularized by the London newspapers.² Indemnities as large as £10,000 are provided. A great many of the larger newspapers in this country have effected arrangements with corporate insurers to issue a special cover to their subscribers. The policy is widely advertised in the press. Either it may be given away with a yearly subscription to the paper, or the paper may contribute a part of the cost.

A typical newspaper accident policy for which the annual premium is only \$1 is outlined briefly here. The application blank is printed in the newspaper, asking only for the applicant's name,

¹ "Airsurance Policy," *Underwriter's Review*, Jan. 16, 1936, p. 5.

² "London Coupon Insurance," *Eastern Underwriter*, Feb. 13, 1931, p. 46.

age, sex, color, and beneficiary. Loss of life or two members through the wrecking of a railway car is indemnified at the rate of \$10,000. Death due to wrecking of a streetcar, steamship, elevated train, or subway in which the insured is riding as a fare-paying passenger entitles him to \$5,000. Monthly indemnity of \$100 for 12 months is provided for injury under the same circumstances. Loss of life in the wrecking of a taxicab or public omnibus, or of a private automobile under certain prescribed conditions, carries a death indemnity of \$1,000. Pedestrian accidents are indemnified at the rate of \$500 for death and \$25 a month for 6 consecutive months for nonfatal disabilities. There are numerous exceptions to the coverage; but, in spite of them, the insured receives a full dollar's worth of protection. The chief fault found with the newspaper policies is that they appeal principally to the gambling instinct of the public and by conferring a degree of protection imbue the insured with the idea that his chief needs are covered, thus impeding the sale of a full-coverage policy. The exact extent of the coverage provided by these policies can only be determined by a careful examination of the policy provisions. In common with all personal-accident-and-health policies, state statutes require that a brief description of the policy be printed in large type on the face and filing side of the policy. This requirement does not usually suffice to call the restricted nature of the coverage to the insured's attention, and some states rule, therefore, that the company must print in red ink across the face of the contract the statement: "This is a Limited Policy—Read It Carefully."

Limited health policies are sold at a somewhat higher premium than limited accident policies and indemnify the insured against loss from a specified list of diseases. Such a list usually includes the contagious diseases, apoplexy, epilepsy, spinal meningitis, and a wide variety of other more-or-less common ailments.

The Automobile-accident Policy.—The automobile-accident policy is one of the more complete special-risk covers in that it includes nearly all the risks pertaining to the automobile hazard. It is issued by all types of carriers for a premium ranging from \$3 to \$12.50 annually. The policy is enjoying a considerable sale owing to the public's realization of the greatly increased hazards caused by the automobile.

The insured is covered against injuries sustained by accidental means while riding as a passenger in a private automobile or public passenger motor vehicle. Indemnities for loss of life and dismemberment range from \$1,000 to \$10,000. Weekly indemnity, usually \$5 per week per \$1,000 death benefit, is provided for total disability limited to 52 or 104 weeks. Hospital benefits are included as well as the identification provision. Partial-disability benefits are limited to 25 to 40 per cent of the total-disability indemnity for 3 or 4 months. The policy covers the insured only between the ages of 18 and 65. Usual exceptions are the following: injuries sustained while the insured is outside the United States, intoxicated, engaged in the commission of a felony, racing, or riding on a motorcycle; those sustained by inhaling gas; those contributed to by disease, mental or bodily infirmity, or hernia; those sustained while the insured is acting as a paid driver for any vehicle.

The introduction of the medical-reimbursement benefit has given the companies an opportunity to stabilize their special automobile policies. Prior to 1935, the most popular type of automobile policy provided large benefits for a small premium in certain restricted contingencies. This contract from the company viewpoint offered too wide a possibility for shock losses. The inclusion of medical reimbursement permits the companies to reduce the amount of death-and-dismemberment benefits and at the same time offer superior protection. A more restricted variation of the medical-reimbursement principle in an automobile-accident policy is exemplified by a contract which provides reimbursement of physicians' fees with the number of calls restricted to five during the week succeeding the accident and three per week for the next succeeding 5 weeks. Hospitalization or nurses' services is indemnified up to \$5 per day, and a death benefit of \$500 is provided. The annual premium for this policy is only \$5.

In 1939, a number of casualty companies brought out as an endorsement to the automobile-liability policy a form indemnifying the insured (the owner or driver of the car) against medical expense incurred by reason of injuries to his guest passengers. It is a question in many minds whether this coverage which on its face would seem to be third-party insurance is not in reality a branch of personal-accident insurance.

Installment-purchase Insurance.—The rise of installment buying has opened another and almost unlimited field for the application of accident-and-health insurance. Although purchasing on installment has been abused by some, it does offer a means by which many people who are in moderate circumstances can acquire many necessities and even luxuries which they would otherwise be forced to do without. To the careful buyer, the installment purchase offers but a single great hazard—the cessation of his income. He may be partly protected against this hazard by securing a disability contract payable to the creditor. Such contracts have recently been devised and are becoming increasingly favored by the merchant and the installment purchaser.¹ In the event of the purchaser's disability, the underwriter makes the regular installment payments for him. These payments are credited to the purchaser's account by his creditor. The indemnity provided by the insurance is the monthly amount due on the purchase, and the limit of the company's liability is the remaining monthly installments with a decreasing aggregate liability as each month progresses. In the event of accidental death, a lump-sum settlement is made in an amount equal to the entire outstanding debt. The premium is paid by the merchant who may bear its entire cost or shift the whole or a part thereof to the purchaser. The plan has already been successfully applied to automobiles, homes, household appliances, and many other installment-purchase articles.

Miscellaneous Limited Policies.—The accident-and-health-insurance business has not been entirely free of promotional activity on the part of persons who are more concerned with merchandising or advertising a particular product or service than they are with providing disability insurance based on sound underwriting principles.

One sales-promotion device contemplates giving a limited accidental-death policy with each purchase. On each sales slip is printed:

For premium received, the undersigned company agrees, that should the death of the holder, if between the ages of 10 and 65 years, occur within 24 hours from noon of the date hereon from direct contact with an

¹ SOMMER, ARMAND, "Manual of Accident and Health Insurance," pp. 26-27.

automobile, to pay to the estate of the holder of this policy \$200, upon proof of death and the surrender of this policy which is not valid unless signed and dated in the holder's own hand on the date acquired.¹

Similar is the policy given by a large mail-order establishment with each purchase of an automobile tire. This policy protects the purchaser of the tire to the extent of \$1,000 death-and-dismemberment benefits if injury be sustained because of the blowout of the tire within 1 year of its purchase. It is apparent that with this type of policy the opportunity for claim fraud is exceptionally great.

Accident-insurance sale by slot machine, although unorthodox, is being tried in some localities. The purchaser of the limited policy drops a quarter in the slot, pulls back the lever, and writes down his name and that of his beneficiary. The machine stamps the time and date on the policy which is then ejected from the device. The maximum indemnity provided is \$7,500 in the event of the insured's accidental death while on a common carrier.² The term of the contract is 24 hours, and it is limited to persons between the ages of 15 and 60.

An accident policy of particular interest to parents is the form devised to indemnify them in the event of injuries sustained by their children while going to, attending, or returning from school, Sunday school, or church. The age limits are 6 to 19. Injuries resulting from participation in football, basketball, baseball, or track sports are not covered. One such policy provides a death benefit of \$1,000 with dismemberment benefits ranging from \$250 to \$500 and reimbursement for the expense of medical treatment, surgery, or hospitalization up to a limit of \$250. The premium charge is \$5 a year.

A number of companies have had considerable success with the *nonoccupational* policy. This contract is designed to appeal to persons engaged in industrial pursuits whose work accidents are covered under state compensation laws. The nonoccupational policy offers protection against injuries which are not within the scope of compensation benefits and against sickness.

¹ "Limited Accident Policy," *Chicago Journal of Commerce*, Apr. 3, 1935, p. 8.

² *Time*, Jan. 24, 1938, p. 52.

These policies are usually available to individual wage earners but are sold most readily on a wholesale basis under a salary-deduction agreement. In establishments which are not exactly suited to a group health policy, it is frequently possible to arrange for a monthly deduction from the pay roll to cover the premium on the policy. Since this coverage does not extend to occupational accidents there is no need for a classification of risks or rating of the premium by occupation. The premiums are on a nonclassified basis.¹

Group Disability Insurance.—The contract by which accident-and-health benefits are issued to a number of people under one cover is called *group disability insurance*. *Group* accident-and-health insurance in this country can be traced back to 1890 when the Travelers Insurance Company granted such a contract to the Board of Fire Commissioners of Baltimore covering all members of that city's fire-fighting force.² The coverage did not crystallize as we know it until 1910 when Montgomery Ward & Co. began casting about for a means of providing disability protection for its employees. The Travelers submitted a plan which the company adopted in part, but the contract was placed with the London Guarantee and Accident Company.³ The first great impetus received by the group form came as a result of the first World War when this insurance was purchased as a means of holding employees during the period of labor shortage.⁴ The coverage grew rapidly after that time, and many companies organized special departments to handle this type of cover. The recognized advantages of the plan include: (1) reduction of labor turnover, (2) increase in employee efficiency by minimizing financial worry, (3) essential benefits for the employee in time of need which he probably would not otherwise have, (4) reduction of cost of the insurance to the individual insured and more liberal coverage than the employee might otherwise be able to secure.

Since the entire cost of such protection is borne by the employer or jointly with the employees through small periodic deductions

¹ *Insurance Field*, Aug. 9, 1934, p. 17.

² *Accident and Health Review*, March, 1936, p. 22.

³ CHAMBERLAIN, W. F., "Group Insurance," in "The Travelers," p. 98.

⁴ WATT, PAUL, "Group Accident and Health Insurance," p. 2.

from wages, the merits of the group plan are dependent not upon any gift by the employer but upon the opportunity afforded for collective bargaining, the resultant low cost, uniform benefits, broader coverage, a convenient method of payment, and the certainty of remaining protected as long as employed.

Group disability insurance falls into three divisions: group accident and health, group hospitalization, and group accidental death and dismemberment. The three may be written in different combinations. Usually, group-hospitalization benefits are not written alone but are supplementary to the accident-and-health indemnities. The names of the forms suggest the benefits they provide. The accident-and-health benefits are weekly indemnities covering loss of time because of nonoccupational injuries or sickness. The hospitalization benefits are a daily allowance for hospital confinement and reimbursement for certain fees. The accidental death-and-dismemberment benefits are payments for accidental loss of life, limb, or sight. The most complete group plans are a combination of the three divisions.

A *master group policy* is issued to the employer, and a certificate of insurance is given to each employee covered. The contract is issued on the yearly-renewable term plan. The application for the group is made by the employer.

As most states have compensation laws in force, the group disability policy usually covers only sickness and nonoccupational accidents. Occupational accident coverage can be secured, however. An elimination period ranging from 4 to 15 days is nearly always included. Benefits are limited to 13, 26, or 52 weeks. The regular group rates apply to groups of 50 or more employees, of whom at least 75 per cent of those eligible enroll. Groups ranging in size from 25 to 50 persons are written at a rate increase of approximately 20 per cent. The insurer is, of course, anxious to include as large a group as possible under the policy in order to mitigate the effects of adverse selection. To counterbalance the selection against the company which results from the voluntary, comprehensive nature of the coverage and the absence of any individual medical examination or application, the carriers make the following requirements: (1) At least 75 per cent of the eligible employees must enroll. (2) The

indemnity payable shall not exceed two-thirds of the insured's regular wages or in any case a fixed amount as \$40 per week. (3) The benefits are limited to a certain number of weeks. (4) Smaller groups and those containing a large number of females will be rated up (if the group contains over 90 per cent women, the rate is nearly double that for a group consisting only of 10 per cent females). (5) Certain more hazardous industries where the health hazard is greater are rated up 15 to 70 per cent. (6) Certain groups of employees and some industries are not eligible for the cover. The employer is made responsible for the operation of the contract provisions; thus it is hoped his influence will reduce malingering.¹ To preclude "floaters," an employee must have been engaged by a firm for a period of 3 to 6 months before he becomes eligible for the insurance. Part-time employees are not covered. One hazard which the insurer cannot escape is the moral hazard involved when the individual employee secures a heavy line of other insurance in addition to his group benefits.²

The group policy differs from the standard accident-and-health contract in several particulars. It cannot be cancelled during its term by the carrier unless the number of employees covered falls below a certain minimum. Readjustment of the premium is permitted upon any anniversary of the policy. It is renewable from year to year at the option of the parties. The group policy is not subject to the Standard Provisions Law, since the employer is assumed to take the place of the state in overseeing the operation of the contract, although as a matter of fact the gist of most of the standard provisions which would apply to the group situation are included in the contract. No application is required of the individual insured. The limitations incorporated in the group policy are simple. They usually require only that the insured be treated by a regularly licensed physician and provide that only disabilities having their inception while the insured is in the United States and Canada shall be covered and that no coverage extends to disability due to war, riot, insurrection, or aeronautics.

¹ KNIGHT, *op. cit.*, p. 324.

² CRAIG, J. D., "Group Health Insurance," *Proceedings of the Casualty Actuarial and Statistical Society*, Vol. VII, pp. 78-103.

The group policy has not yet reached the stage in its development where its form is definitely set. For many years, the only statutory provisions concerning group disability contracts have been directed at exempting them from the Standard Provisions requirements of personal accident-and-health policies. These exception clauses have been the vehicle for defining the scope of the group field. A typical law includes in the group field general or blanket policies issued

. . . to any municipal corporation or department thereof, or to any corporation, co-partnership, association, or individual employer, police or fire department, underwriters' corps, salvage bureau, or like association or organization, in which the officers, members, or employes or classes or departments thereof are insured for their individual benefit against specified accidental bodily injuries or sickness while exposed to the hazards of occupation or otherwise in consideration of a premium intended to cover the risks of all persons insured under such policy.¹

In order that the field of group accident-and-health insurance may be defined and a degree of uniformity as to policy provisions attained among the different states, leaders in the business have long urged that a standard act be adopted. To forward this end, committees of both the National Association of Insurance Commissioners and of interested carriers have worked out carefully drawn proposals. Section I of the proposed act written by an advisory committee of representatives from the Health and Accident Underwriters Conference, the Bureau of Personal Accident and Health Underwriters, and the Group Life Association sets up a definition of group accident-and-health insurance. The substance of this committee's recommendations has been enacted into law by several states and bids fair to become the universal standard. Any contract of insurance against loss or expense occasioned by death or bodily injury resulting from accidental means or against loss or expense resulting from sickness or disease and which covers more than one person, except blanket policies and family-expense policies, is deemed to be a group disability policy. No such contract may be issued except to an employer covering 25 of his employees with or without

¹ *State of Connecticut Insurance Laws, 1938, Sec. 4228.*

their dependents and with or without medical examination or to an association having a constitution and by-laws and formed in good faith for purposes other than of obtaining insurance, covering at least 25 members with or without their dependents and with or without medical examination. The term "employer" as used is deemed to include any and all governmental departments, agencies, and corporations. The term "employee" extends to officers, managers, and other employees not only of the insured employer but of affiliated and subsidiary corporations and firms as well. Any of the benefits of the contract covering hospital, medical, or surgical expense may be extended so as to cover dependents of insured employees or members.

Section II of the proposed law requires that no policy of group accident or health insurance shall be issued in the state until a copy of the policy form together with all forms of application, riders, and endorsements shall have been filed with and approved by the supervising insurance official of the state.

Section III provides that the substance of certain Standard Provisions must be incorporated in the master policy. The gist of these provisions follows:

1. A provision that the policy, the application of the policyholder, and the individual applications of the certificate holders, if any, shall constitute the entire contract and that no statements made by the applicant shall avoid or reduce the coverage unless contained in the written application of the applicant; no agent has the authority to alter the policy or waive any of its provisions; no change in the policy shall be valid unless approved by an officer of the insurer and endorsed on the policy.

2. A provision that all statements contained in any such application shall, in the absence of fraud, be deemed representations and not warranties.

3. A provision that periodically new employees or members must be added to the groups eligible for insurance.

4. A provision that the insurer will issue to each employee or member of the group a certificate stating the benefits and essential provisions of the policy.

5. A provision stating the conditions under which the insurer or policyholder may renew or terminate the policy.

6. A provision specifying the ages to which the insurance shall be limited and the ages at which additional restrictions, if such there be, are placed upon the benefits.

7. A provision that written notice of disability must be given the insurer within . . . days of its inception or, if this is not possible, as soon as is reasonably possible.

8. A provision requiring that the insurer be furnished with written proof of disability within . . . days of the commencement thereof and periodically during its continuance.

9. A provision relating to the insurer's duty to furnish the claimant with forms for establishing proof of loss.

10. A provision that failure to furnish notice or proof within the time required by the policy shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to so furnish notice or proof and that such notice or proof was furnished as soon as reasonably possible.

11. A provision giving the insurer the right to examine the insured in the event of claim or do an autopsy in case of death where not prohibited by law.

12. A provision relating to the time within which the insurer must pay the indemnities provided.

13. A provision specifying that consent of the beneficiary is not necessary to changes in the certificate or policy.

14. A provision setting the time limits within which suit may be brought under the policy.

A final section of the recommended act deals with parties to whom benefits under group policies may be paid. Indemnities shall go to the insured employee or association member if living; otherwise, to his specified beneficiary who shall be related to him by blood or marriage; otherwise, to his estate. No employer or officer of an insured association may receive indemnity because of the disability of an insured employee. Benefits covering hospital, medical, or surgical expense may be paid to the physician or hospital rendering the service, if the insured employee does not survive to receive the payment himself.

The nationwide enactment of the recommended model act would be a definite boon to the group business. It would accomplish a desirable uniformity in the working provisions common to all policies of this type, serve to increase the popular

understanding of the coverage, and relieve the companies of the expense of complying with widely varying requirements in different states.

The Manchester Unity Table (1907) was adopted by Dawson and Cammack as the basis for their group rate making, and they assumed in calculating the premium that all employees were at age 40. It has become a uniform practice to refuse group coverage where the risk involves: (1) a substandard class of employees; (2) substandard working conditions; (3) work of a purely seasonal nature; (4) the use of acids, poisons, dyes, gases, or similar hazardous¹ materials.

Where the group consists of 300 or more employees on a standard basis without unusual conditions, one large insurer includes a provision in the contract, which, whenever the experience is favorable, will entitle the employer to benefit through the return of a portion of the premium paid. Such a divisible-surplus agreement is a good basis for securing cooperation between employer and insurer and encouraging the institution of safety measures and better working conditions among the employees.

Almost as much variation is noted in the benefits afforded under group contracts as characterized the personal policy.² The benefits will differ among companies and individual plans. Accidental-death benefits range from \$1,000 to \$5,000. The bulk of these benefits are \$3,000 or less. Weekly indemnities range from \$7 to \$40. The group-hospital contracts carry a predetermined daily benefit of \$2 to \$4 for each day's hospital confinement, limited to 21 to 70 days. There is also actual reimbursement of the employee for fees incurred for anesthesia, laboratory, and operating room but not to exceed five times the daily benefit.

Group insurance policies have been developed to meet special needs. Particularly important are the policies in force covering schoolteachers and volunteer firemen. Schoolteachers are eligible for a relatively liberal type of group coverage as long as they are employed by a regular school board. Death-and-dismember-

¹ Zurich General Accident and Liability Insurance Company, Ltd., "Prospectus on Group Disability Insurance," p. 3.

² CHAMBERLAIN, *op. cit.*, p. 101.

ment indemnities, benefits for total and partial loss of time due to accident and sickness, and hospital benefits are included. The policy is not effective during summer-vacation periods.

The volunteer-firemen's policy is widely used in municipalities which do not employ a full-time fire-fighting force. This special policy provides blanket accident-insurance coverage to the members of the fire company indemnifying them in case of death or total disability caused by accidental means and sustained while the member is actually on duty as a fireman with the fire company. Injuries incurred while going to, while at, or while returning from fires or while at tests, trials, fire drills, or other activity of the fire brigade are covered. Any salaried or regularly employed member of the force is covered only while actually going to, while at, or while returning from a fire. The principal sum provided varies from \$1,000 to \$2,000, the weekly indemnity from \$10 to \$25 with a 52-week limit. One week's total-disability indemnity is usually the limit of reimbursement for medical treatment of a nondisabling injury. Hospital benefits may be added for a slight extra premium. The usual exclusions include injuries sustained through, resulting in, or complicated by hernia, bodily infirmity, bacterial infections, or disease incurred while the insured is under the influence of an intoxicant or narcotic.¹

Group insurance is sometimes used in partial replacement of workmen's-compensation insurance. One company has originated a policy closely paralleling the benefits provided by compensation laws. Its appeal is to the smaller groups in hazardous occupations which are subject to a very high compensation-insurance premium. Many of these employers elect not to be subject to compensation laws because of the size of the insurance premium. The group policy has been developed to afford these employers a measure of insurance protection. The employee's right to sue his employer under the law of negligence is not abridged by the group policy.²

Group-sports policies have become popular. They are sold to colleges and schools to indemnify students injured during partici-

¹ SOPER, L. B., "Study Outline of Accident and Health Insurance," p. 91.

² "Group Accident and Health Substitute for Workmen's Compensation," *Chicago Journal of Commerce*, Jan. 27, 1936, p. 8.

pation in the school's sports program. All sports scheduled during the school term are covered. Benefits apply to any injury incurred by the students while playing, practicing, or in transportation to or from any game or meet. Indemnities are included for death and dismemberment, scheduled fractures, dislocations, and other injuries. Reimbursement for hospitalization and medical treatment is on the allocated plan.

Of more general application is the group-hospitalization policy introduced in some colleges. For an annual premium of \$12, hospital, nurses, and medical expenses exceeding \$10 are covered up to a limit of \$250. Surgical operation fees are covered also, up to \$250. Summer-vacation periods as well as the regular school term are covered, and the graduating seniors are covered up to 1 year after leaving school regardless of their location. Sixty per cent of the student body must be enrolled in the plan.¹

Since the group policy is somewhat subject to a shifting hazard through increase or decrease in the persons covered or alterations in their wages, the employer is required to pay a tentative advance premium and keep a separate insurance record to which the company has access. Adjustment of the premium is made monthly in accordance with the exact amount of coverage which was extended.

Group coverage is apparently here to stay. It weathered the depression relatively unscathed. Its potentialities for social service and the economy and soundness of its performance all point to the part of increasing usefulness which it will undoubtedly play in the scheme of industrial life.

SUMMARY

The various types of contracts issued by accident-and-health-insurance carriers may be summarized as follows:²

1. The general accident policy, insuring against all accidents.
2. The general accident-and-health contract, insuring against all accidents and sicknesses.

¹ "Vassar Group Policy," *Accident and Health Review*, January, 1936, p. 22.

² LAMONT, STEWART M., "The Contract of Personal Accident and Health Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. XVIII, p. 51.

3. The noncancelable accident-and-health policy, insuring against the same hazards, with right of renewal vested in the insured.

4. Restricted accident policies, giving wide coverage at a popular price, with some restrictions.

5. The limited accident policy, insuring against specified accidents.

6. The limited health policy, indemnifying loss resulting from listed diseases.

7. The group accident policy insuring a large number of persons under a blanket policy without benefit of individual selection, and usually limiting indemnity to the major losses of life, limb, or sight.

8. Group health policies, blanket covers providing indemnity for sickness or nonoccupational accidents.

In addition, earnings protection is granted in one form or another by life-insurance companies through their double-indemnity clause for accidental death and the disability-annuity supplement by casualty-insurance companies through workmen's-compensation insurance and employers'-liability insurance and by group-hospitalization associations providing hospital services.

The major provisions of all these forms have been analyzed with the exception of noncancelable accident-and-health insurance which will be treated in Chap. XII. A knowledge of all types of earnings protection is important to a thorough understanding of the practices and problems of the business. The same fundamental underwriting principles are basic to all the forms.

CHAPTER VI

SELECTION OF RISKS

The problems of *underwriting* personal accident-and-health contracts are numerous and so interwoven as almost to baffle attempts at segregation and analysis. The underwriting process, which includes selection, classification, and evaluation of the risk, is the very heart of any insurance business. If the process is carried on carefully with due regard to past experience and the recognized principles of the business, the carrier has a good chance of enjoying some measure of success. If the underwriter is a gambler, leading the carrier along uncharted courses and taking speculative chances, the company will sooner or later be faced with financial embarrassment or will wind up in the courts. No company can continue to operate if year after year it sustains an underwriting loss, *i.e.*, if the losses incurred and expenses paid exceed the premiums earned. Since the underwriting process is so much the center of the insurance transaction, it is worthy of considerable attention. If the unsatisfactory experience of the depression years beginning in 1929 served no other purpose, it directed the attention of accident-and-health circles increasingly to an examination of underwriting practice in an effort to establish improved standards.

This and the succeeding chapters treat the processes of selection, rating, and reserves as the underwriter faces them, in that order, when dealing with a given risk.

Though it is true that almost everyone has need for accident-and-health insurance, it by no means follows that everyone is insurable. Insurance has been defined as "the distributing of the losses of the unfortunate few among the many exposed to the *same risk*."¹ The rate-making task of the underwriter consists in ascertaining the probable loss cost and probable expense for each member of a given group, according to the degree of hazard

¹ Connecticut General Life Insurance Company, "Accident Insurance," p. 19.

involved. The underwriter acts for the company, binding it in one case, refusing coverage in another, specifying conditions and rates in all cases. The individual risks assumed are never exactly alike, nor does the rate applied in each case precisely measure the hazard assumed. It would be impractical if not impossible to refine the technique of rate making so as to quote an individually correct rate for each risk. It is sufficient that the premium charged be reasonably accurate. This inherent variability among risks imposes upon the underwriter the serious responsibility of seeing that the risks assigned to each class are not the worst or below the average of the class.¹ The underwriter must consider the interests of the applicant and agent as well as those of his company. Primarily, he must secure a safe and profitable distribution of risks, avoiding adverse selection and concentration of risk while procuring an adequate volume. He must beware of the dangers of carelessly drafted policies and recklessly selected risks. This must be accomplished with due regard to the welfare of the agent who has produced the business and in fairness to the applicant who is entitled to as exact a classification of his risk as possible. Strictly, "an underwriter is a person who is skilled in the estimation of a risk and the proper terms of its acceptance by an insurance carrier."² The qualifications of an expert underwriter are exacting. He must have a thorough knowledge of his company's policies, rules, and practices. He should be something of a doctor, being familiar with anatomy, disease, medical terms, and impairments, and something of a lawyer, knowing the rudiments of insurance and business law. He must appreciate the hazards of different occupations and know the duties of the workers. He will have occasion to draw upon his information about other carriers' policies, about his own agents, their production and dependability, and about the experience of the business in given localities and with different types of risk. His work demands sound judgment, tact, integrity, imagination, and intuition.³ One qualified authority has said of the underwriter:

¹ MOWBRAY, A. H., "Insurance," 2d ed., p. 360.

² *Ibid.*, p. 360.

³ SOPER, L. B., "Study Outline of Accident and Health Insurance," p. 27. For a discussion of the general principles of underwriting and rate-making,

He must know his subject—he must know how to appraise insurability—but that is not all, he must know his company, its motives and traditions, its past experience and trend in future business. He must know human nature. He must analyze applicants and the motives which actuate them. He must understand agents and have a sympathetic appreciation of their problems and complexities. It is his opportunity to cooperate rather than restrict—to conserve business rather than reject it.¹

His purpose should be to find a satisfactory basis upon which an application may be accepted rather than to look upon all impairments and irregularities as obstacles to issuance of a policy.

In the exercise of his difficult and important function, the underwriter has certain sources of information which yield the raw material for the evaluation process. Most important of these is the application itself which furnishes the risk's own answers to questions vital to underwriting. Collateral information supplied by the agent may be helpful. An *inspection report* (an independent factual analysis of the risk) can be secured from a professional investigator or organization. The underwriting practices of the companies vary, but most concerns make it a routine matter to procure a confidential report on all applications for indemnity exceeding a certain amount such as \$5,000 principal sum or \$25 weekly indemnity, on all business produced by new agents, or on applications coming from certain localities. The underwriter can usually obtain a report from other companies which have had experience with a risk and can check any previous claim or underwriting experience of his own company with the applicant. In doubtful cases, he can order a medical examination made and secure statements from any physicians who have attended the applicant. The tools available to the underwriter are becoming more adequate as the companies gain and preserve a record of their experience on individual risks, in different localities, and secure more complete analyses of underwriting results by age groups, sexes, occupations, and type of policy.

see: G. F. Michelbacher, "Casualty Insurance Principles," Chap. XII, and A. H. Mowbray, "Insurance," 2d ed., Chap. XXI.

¹ American United Life Insurance Company, "Underwriting Intangibles," p. 3.

Indicative of the experimentation with new methods of measuring a risk is the suggestion that graphology, the science of handwriting analysis, be applied to selection. Graphologists assert that a man's handwriting betrays such important factors as suicidal intentions or the existence of tremor and valvular heart disease. They hold that graphology can be applied as a valuable supplemental check upon other underwriting methods.¹

The first step in the underwriting process is the selection and classification of the risk. Some risks are uninsurable because the hazard involved is too high to be underwritten successfully. These must be culled out and rejected. Others which are acceptable to the company must be judged from the standpoint of the degree of risk they represent in order that they may be properly classed for rating purposes. The chief factors affecting underwriting selection are the applicant's age, sex, race, physical condition, previous medical history, occupation, moral and financial standing, other insurance, type and amount of policy applied for, insurance record, and, to a small degree, family history.²

The underwriting process is carried on by two types of underwriters. The one is the agent, and in some respects he is the more important; the other is the underwriter in the home office. Since the information gathered by the agent is the chief tool used by the home-office underwriter in classifying and rating the risk, it is extremely important that the data given be complete and accurate. The agent in writing the business exercises a marked influence upon the ultimate selection of the company by the type of risk he solicits. If he habitually solicits persons who will make undesirable policyholders, the underwriter's hands are more or less tied if he hopes to put any business on the books whatsoever. Every agent who witnesses an application becomes an underwriter. He originates the business. The home-office underwriter has no choice but to act upon the applications as they come in. By submitting an application, the agent implies that he recommends it. He is the primary force in the selection of risks. Dr. Dingman has rightly said: "The field underwriter con-

¹ NASH, L. R., "Can Handwriting Analysis Help Cut Losses," *Weekly Underwriter*, Sept. 5, 1936, p. 5421.

² DINGMAN, H. W., "Insurability, Prognosis, and Selection," p. 5.

trols the future of disability insurance.”¹ Since the agent initiates the business and thereby determines its grade, the companies have set up certain standards by which the agents are to govern themselves in the selection of the risks they write. These rules are universally contained in the company rate manual under the head “Instructions to Agents” or “Underwriting Suggestions.”

Age.—The underwriting standards which the companies set up are the criteria by which the applicant is judged on the several points involved in the underwriting process. *Age* is a prime consideration in both accident and health insurance. For the ordinary forms, the age limits are 18 to 54 or 59 years for males, 18 to 49 or 54 for females. Policies may be renewed to 65 or 70, but usually no new risks are bound after age 59. The age limits may be more restricted according to the type of policy, occupational hazard, and sex of the applicant under consideration. Age is determined as of the applicant's last birthday. The companies have preferred not to grant coverage to persons under 16 or 18 years because of the uncertainties which attend their incomes. On special policy forms such as the school child's reimbursement accident policy, the eligible age is much lower. Applicants under age 18 frequently present an unstable hazard. The occupation is subject to change; and often, with no family or other responsibilities, the young risk is more inclined to be careless or knowingly to run risks which would be avoided by a person of more mature judgment. Some legal problems also arise out of the minority of insureds under age 21.

The problem of the “overage” risk is more pressing than that of the minors, for it affects insureds who may have carried the protection for many years as well as older men and women who wish to secure insurance. Many risks attain age 65 in full enjoyment of their physical vigor and mental alertness. Being still dependent upon their earning power for their maintenance, these people have a real need for earnings protection. This need is being recognized increasingly by the underwriters, notably London Lloyd's, who have made special coverage available to the overage risk. Some carriers have extended the top age limit to which they will carry the policyholder, and others have made especially designed “overage policies” available to these risks.

¹ DINGMAN, H. W., “Personalities in Insurance,” p. 16.

There are many obstacles connected with insuring persons over age 65. Older men and women present primarily a physical hazard. Their reactions are not so quick as those of younger persons, and they are predisposed to injuries which the more alert and agile can avoid. The degenerative diseases of old age retard recovery from injury and are in themselves the cause of considerable disability. Because the recuperative powers of the body at advanced ages are not so great, relatively minor injuries may terminate in death or may result in a longer period of disability than for the normal insured. At the older ages, it is difficult to secure an average experience because the spread is not great. Retired risks do not need or cannot afford the insurance, and other oldsters are not eligible on physical grounds. The moral hazard on this type of business is likely to be great because of the higher premium rates which tend to self-selection and because of anticipated greater morbidity. These objections to insuring persons at the older ages are mitigated to a degree by certain compensating factors. The high severity of disability rate presented by older people is offset by the higher frequency of disability rate at the younger ages. The risks which remain on the books for many years usually represent a select group which has survived the test of time. It is seasoned business. The greater caution of ripe old age makes up in part for the loss of agility. Then there is to be considered the company's natural disinclination to retire from the risk of a policyholder who may have been a loyal client for 20 or 30 years. Such a policyholder is apt to consider himself as good a risk as ever and resent losing his protection. His dissatisfaction may result in the disaffection of his relatives and friends.¹ At least one company has met the problem of the average risk on its accident forms by providing that when the insured attains age 65 the amount of the indemnities provided shall be reduced 50 per cent, the premium charged remaining as before. The insured is then permitted to carry the protection indefinitely.

Sex.—*Sex* of the applicant is important in underwriting because experience indicates that uniformly lower indemnity and age limits should apply to women than to men. Some

¹ "The Overage Problem," *Accident and Health Review*, Vol. XXX, No. 7, July, 1937, p. 1.

companies do not extend coverage to women under any policy. Others have devised special types for female applicants. Nongainfully occupied women, *i.e.*, those not engaged in employment for hire, and married women regularly employed and living with their husbands are not eligible for the weekly-indemnity coverages in most commercial companies. Likewise, domestics, seamstresses, and female workers whose place of business is in the home are seldom granted weekly-indemnity benefits. Such a practice is necessary because women who are not gainfully employed do not suffer a cessation of earnings upon disability. Further, it is extremely difficult to establish the length of disability suffered when the woman's place of employment is in her home. To grant weekly indemnity to such classes would encourage malingering and unjustified claims. The companies do offer accidental-death-and-dismemberment policies for housewives. Such policies carry a long schedule of lump-sum settlements in the event of specified accidental injury, in addition to the death benefit. The weekly-indemnity forms are granted by most companies only to regularly employed women, engaged in a stated occupation from which they derive a regular salary on which they are dependent for support. Employment must be continuous the year around, subject to an annual vacation of not more than 4 weeks (except for schoolteachers and graduate nurses). A few underwriters have enjoyed an excellent experience on restricted loss-of-time policies issued to housewives. If carefully underwritten within reasonable limits, the risk has proved attractive for them. The medical-reimbursement form has opened a splendid new approach to the nongainfully employed female risk. Combined with death-and-dismemberment benefits, medical-reimbursement insurance offers a policy with a great appeal to the housewife and one which protects her against her principal hazard. The underwriter's attitude toward the female risk has undergone a gradual liberalization since the first World War. The number of women engaged in industrial and professional pursuits has increased greatly. The 1930 census disclosed that there were 10,750,000 employed women in the United States. They represented 22 per cent of the entire self-supporting portion of our population. It was estimated that 91 per cent of these women were without reserves, being solely dependent upon their

earnings.¹ The economic emancipation of women has improved their risk by giving them more insurable value.

Certain occupations in which women engage are looked upon with greater favor than others by the underwriter not only because the inherent occupational hazard is smaller but because the continuity of employment minimizes the moral hazard. These occupations include stenographic and office positions, teaching, and the other professional pursuits. Demonstrators, book agents, traveling saleswomen, women working on a commission basis, beauty-parlor attendants, hairdressers, and manicurists are usually handled on a more restricted basis. The limits of indemnity applied to female risks are uniformly lower than for males. One leading underwriter sets the following maximums for women: accident insurance—principal sum \$10,000, weekly indemnity \$50; medical reimbursement—\$1,000; health insurance—weekly indemnity \$25. On the health-insurance forms, many underwriters insist on at least a 7-day elimination period for women.

Disability and time loss due to child bearing is a hazard which the underwriter must contemplate in the female applicant under middle age. Although probably outside the scope of accident-and-health coverage as defined in the insuring clause, being neither the result of accidental means nor a disease in the accepted sense of the term, pregnancy, child birth, miscarriage, or the effects thereof are specifically exempted from coverage in practically all disability policies issued to women. Even when unanticipated, the nature of this condition permits the opportunity for financial preparation prior to disability.

There is no reason to believe that females cannot be underwritten successfully provided that proper adjustments are made in the coverage to care for the known peculiarities attendant upon insuring the female risk. If indemnities are kept within reasonable limits, recognition is given to certain physical and neurological factors, and the importance of the woman's earning power is carefully determined, no unusual difficulties should be encountered. A recent survey of inspections made of applicants of both sexes for disability insurance revealed that of some

¹ BROOKE, L. S., "Women as Insurance Risks," *Inspection News*, September, 1935, p. 3.

24,479 cases reviewed the percentage of women who presented unfavorable underwriting situations (12.7 per cent) was lower than the average of 16 per cent unfavorable for the whole group.¹ When insuring married women, it is of some significance whether the husband carries insurance. If the husband is employed but not insured, the presumption is raised that insurance is taken on the wife in anticipation of disability. It has been asserted by some claim men that they experience greater difficulty in effecting fair adjustments with women, but in spite of this and other objections to writing women the volume of this type of business continues to expand. The underwriter must accommodate himself to the requirements of the situation and work toward an increasingly liberal and satisfactory handling of insurance on females.

Race and Nationality.—*Race* and *nationality* are important factors in selection. It is the usual practice among commercial and industrial insurers to underwrite only members of a single race. The underwriting problems involved in attempting to insure members of more than one race would be considerable owing to differences in physique, temperament, habit, and environment. Thus, some organizations exist for the purpose of extending disability benefits solely to members of the white race, others solely to Negroes. The agent is often expressly instructed that solicitation must be confined exclusively to those persons who can read, write, and speak English and who are intelligent enough to understand the nature of a contract. Some industrial carriers do not impose so stringent an educational requirement, simply stating that the prospect must be able to speak and understand English. Generally speaking, when race is a factor in underwriting, particular consideration should be given to the occupation of the applicant. If the amount of indemnity applied for is large or if there is no distinct need apparent, it suggests a speculative element. The carriers' experience with fraud rings involving collusion and substitution of risks, particularly in the more populous centers, indicates that Asiatics and persons of southern European derivation are most prone to speculate on the lives of relatives.

Underwriters universally prefer applicants who are American born. The carriers' experience has been built up on the basis of

¹ *Ibid.*, p. 3.

insurance on American lives. Members of other nationalities do not present the same morbidity hazard as Americans. Likewise, owing to "clannishness" or lack of understanding of American institutions, it is hard to secure accurate proof of loss of time and to effect satisfactory adjustments with persons of foreign birth. One company lists the following as nationalities which it cannot satisfactorily insure: Armenians, Chinese, Greeks, Japanese, Mexicans, Spaniards, Russians, Assyrians, and Turks. Some persons who are natives of these countries but become thoroughly naturalized Americans will be given consideration.

Residence.—*Residence* has an important bearing upon insurability. Applicants who plan to reside outside the United States or Canada usually are rejected. The hazard of disease or accident in foreign countries is not calculated in the premium computation. Morbidity records indicate that residents of the southern areas of the United States are poorer risks than the people of the more temperate zones. In an investigation of the combined health experience of the member companies of the Bureau of Personal Accident and Health Underwriters, for 1921–1926, it was found that the average number of weeks of total disability experienced per year of exposure ranged from 0.63 for the Middle Northern states to 0.69 for the Southern states and 0.71 for foreign locations.¹ The adjustment of claims presented by policyholders residing in small out-of-the-way places where a carrier has no medical examiner or local agent occasions delay and expense, and it is urged for practical reasons that agents solicit only risks who reside within a reasonable distance from local agencies. Recent changes in residence are matters of interest to the underwriter. An investigation of the cause of such change may reveal conditions which would make the applicant undesirable. Residence of less than 5 years' duration in states like Arizona, Colorado, or New Mexico raises the question of whether or not tuberculosis or a similar affliction is present.

Physical Condition.—The *physical condition* of the prospect is especially significant. The application is so designed as to reveal the salient points in regard to the prospect's health, but unscru-

¹ "Combined Health Experience," *Report of the Committee of Five on Statistics of the Bureau of Personal Accident and Health Underwriters* (1932), pp. 139–140.

tion on the policy relieving the company of liability in the event of injury or disease involving the unaffected eye or for loss of vision of either or both eyes.

Defects of the limbs and joints constitute another important class of impairments. Applicants who have lost arms below the elbow or legs below the knee are given some consideration. But persons suffering from deformities due to tuberculosis, paralysis, or chronic arthritis or who are compelled to use a crutch, cane, or mechanical brace or who have had amputations above the knee or elbow are generally considered uninsurable.

In fairness to all concerned, the underwriter strives to provide some sort of insurance for certain types of substandard risks. The companies are in the business of providing protection, and if a person is insurable at all the underwriter will devise some coverage for him. Typical of impaired risks to whom can be issued policies with special riders attached waiving liability on their individual defects are applicants presenting a history of:¹

Back injury	Mastoiditis
Bursitis	Neuritis
Deformed limbs	Otitis media
Gastritis	Prostatitis
Goiter (simple)	Respiratory diseases
Hay fever	Sinusitis
Hernia (rupture)	Sports hazards
Hydrocele	Tonsillitis (without operation)
Kidney stones	Urethral stricture
Loss of hand or arm	Varicose veins
Loss of toes, one foot, or one leg below knee	Vision impairment
Lumbago	Weakness due to previous injury

The rider need not be a complicated endorsement. Many companies favor a simple statement: "On and after date this policy does not cover or extend to any disability resulting directly or indirectly from." The rider should be dated, should be signed by an executive officer of the company, and should bear the policy number. Some companies insist upon the signature of the insured to the waiver.

¹ SOPER, *op. cit.*, p. 30.

By and large, a repeating history of the foregoing disablements strongly forebodes further disability. The rider makes it possible to insure risks which without a waiver would be uninsurable. The insured gets his money's worth; for, even with liability on account of the chronic condition eliminated, its existence may make him more susceptible to or may prolong disability from other causes. Waivers are frequently misunderstood and, unless their use is carefully interpreted for the agent and applicant, may be the source of considerable dissatisfaction. It should be pointed out that by the application of a waiver the necessity for rejecting many applications or canceling much insurance is overcome. A judicious use of riders permits the agent to place more business. It deprives the substandard insured of only that degree of full coverage made necessary by his impairment.¹ If the policyholder fully understood the coverage, riders would not be necessary in connection with new policies issued to substandard risks, for no accident or sickness policy contemplates covering conditions which antedate the contract. The rider does serve, however, to give formal written recognition to the impairment existing at or before the time of policy issue. This serves to eliminate the possibility of future argument if a claim should arise.

Waivers should not be used in all cases of impairment, particularly if the applicant is afflicted with a chronic condition or serious ailment which will have a pronounced effect upon his general insurability. In some cases, the underwriter compensates for existing impairments by accepting the risk with a 10- or 15-day elimination period written into the contract. For instance, the risk who suffers from an attack of *la grippe*, or influenza, every winter might be accepted as satisfactory with a 15-day elimination period. Similarly, cases presented within 6 to 12 months of a serious ailment such as brain concussion or a major operation should be postponed a reasonable time to demonstrate complete recovery.

Though no office underwriter expects the agent to be so adept at diagnosis as a physician, he does rely upon him to observe the applicant carefully and report any noticeable physical signs or symptoms which could give a clue to his insurability. Typical

¹ HAUSCHILD, E., "Underwriters Guide," p. 199.

are the following danger signals which an alert agent should note and report:¹

Sign	Probable Condition
Marked underweight.....	Possible tuberculosis, malnutrition
Marked overweight.....	Poor health habits, glandular disorders
Puffy rings under eyes.....	Kidney trouble, nephritis
White or blue lips.....	Heart trouble, anemia
Waxy skin.....	Nephritis, anemia
Yellow discoloration of eye balls...	Liver trouble, jaundice
Flushed cheeks.....	Tuberculosis, valvular heart disease
Clubbed finger tips.....	Tuberculosis
Blue fingernails.....	Heart disease, circulatory disorders
White saddle across bridge of nose.	Low vitality
Notched teeth.....	Syphilis
Lead-colored face.....	Heart or kidney disease
Lagging of upper eyelids.....	Goiter
Inequality in size of pupils.....	Syphilis
Bronze- or Indian-colored skin.....	Disease of spine or lymphatic system

Build—a person's stature, his proportions, and the relation of height to weight—is an extremely important underwriting consideration in all types of personal insurance. A man's build is a significant index to his general health. Although the converse is not necessarily true, it may be said that the build of healthy persons will fall within well-established normal limits. Marked variation from the standard is always a cause for investigation and special consideration. Generally, underwriters require a medical examination if a risk is more than 20 per cent underweight or 40 per cent overweight. Persons under 4 feet 10 inches or over 6 feet 4 inches in height are likewise usually subjected to medical examination.

The hazards of overweight come late in life and often result in sudden death. This fact tends to raise the incidence of claims among the obese, but the cost is generally below average because of the short duration of so many of these cases. There is some indication that overweights are more subject to injury than the average risk or even the underweight. They furnish a bigger target and are less agile. The mere fact that a person is overweight may prolong disability and make it more serious. For example, a heavy person is more subject than the normal risk to

¹ Health and Accident Underwriters Conference, "Underwriting Handbook," p. 19,

sprains and dislocations of the ankle. Because of his weight, he is unable to regain the use of the limb as promptly as the average risk. An added hazard involved in extending accident insurance to risks impaired in this way is the danger of sudden death due to apoplexy or heart disease. Not infrequently, such deaths occur under circumstances strongly suggestive of an accident, and the company is faced with the often difficult task of establishing that the death did not result through accidental means. An excessive girth in comparison with chest measurements is a bad sign indicative of poor muscular development. An overweight condition taken in conjunction with some other impairment, such as high blood pressure, makes a very bad picture for insurability.

An underweight condition is regarded with suspicion chiefly because it may be symptomatic of an existing disease, such as malnutrition, anemia, or tuberculosis. If an underweight case is presented, the underwriter's inquiry will be directed to ascertaining the cause of the slight build.

Family History.—Tuberculosis, nervous disease, and insanity are "the big three" of disability. Since these diseases have a hereditary aspect or since at least a susceptibility to them is thought to be inheritable, the risk's *family history* is important. A recent familial record of apoplexy, diabetes, nephritis, syphilis, insanity, alcoholism, epilepsy, or tuberculosis (if the applicant is under age 35) calls for caution on the part of the underwriter. Not only does a man inherit certain impairments from diseased parents, but he may receive their temperamental quirks and mental traits. But not all inherited characteristics are a detriment to insurability. A tendency to overweight in a healthy family may assist the heavier-than-normal applicant to qualify for insurance.

In connection with family history, it is well to note that the approach of the life underwriter and the disability underwriter differ. The life underwriter is primarily interested in longevity which is a definitely established family characteristic. Good life risks are not necessarily good accident-and-health risks. For instance, asthma and skin disease are both definitely disabling but seldom fatal afflictions. Underwriting for family history has not been developed to so fine a point in disability insurance as in life insurance.¹

¹ See MACLEAN, J. B., "Life Insurance," Chap. V.

Moral Hazard.—Closely related to physical condition is *moral hazard*. This is necessarily a broad term loosely including those intangibles which cannot be classified definitely but whose existence removes a risk from the standard group. Moral hazard reflects the risk or chance resulting from the failure of individuals who are or have been affected by a policy of insurance to uphold the accepted moral qualities. It has to do with the attitude of the insurance buyer toward the policy he is applying for—whether he regards his insurance as protection or as a means to an income. Moral hazard is basic in all insurance underwriting. No single factor equals it in importance in determining the acceptability of a risk.¹

Moral hazard will disqualify any risk; for, regardless of the physical excellence of an applicant, if he is the prey of certain habits or weaknesses he will be an almost inevitable loss to the company. Moral hazard results in fraudulent claims or the exaggeration of legitimate claims. It is encountered in connection with the insured, those intimately associated with him, unfair or careless agents, unscrupulous adjusters, and members of the public who have a selfish interest in the settlement of a claim.² It shows up in the failure to disclose, or in misrepresentation of, important information, in suppression or distortion of situations surrounding the claim or risk, or in malingering.

Since moral hazard is a psychological rather than a physical problem, it is somewhat difficult for the underwriter to evaluate. It involves the mental attitude of the applicant toward his insurance and his moral stamina to stand upright in case of adversity.³ In underwriting for moral hazard, reliance must be placed upon indexes such as an individual's habits and mode of living, his reputation and standing in the world, and his credit record, associations, work, and environment. Persons who are not in tune with society are due for minor and major collisions as they go on their way. They are the neurotic types, at the mercy of moods often aggravated by physical defects, or the hot-tempered pugnacious individuals in occupations not suited to their temperaments. They include the outright undesirables, the sex perverts,

¹ See MICHELbacher, G. F., "Casualty Insurance Principles," Chap. XIII.

² HAUSCHILD, *op. cit.*, p. 4.

³ DINGMAN, H. W., "Insurability, Prognosis, and Selection," p. 3.

adulterers, panderers, racketeers, confidence men, and gamblers. In their ranks is the person "who enjoys poor health" and leans upon the insurance company to finance his self-indulgence. The worst cases are not the out-and-out crooks but the "investment buyers" who, though usually law-abiding citizens, feel they should get back more each year than their premiums and the "weak sister" who goes to bed with the slightest pain or snuffle.

An applicant's habits offer an important clue to the moral hazard. An inspection report made by a reliable reporting service will frequently furnish the answers to such important questions as: Is the risk a fast, careless automobile driver? Has he a record of frequent accidents? Does he imbibe too freely? Has he quit drinking? Why? Has he any previous insurance-claim history?¹ An accurate check on the moral hazard of a risk is not always easy to secure. This is particularly true of wealthy or influential applicants whose indiscretions are usually hushed up. They have a small, select, and discreet circle of friends and a private physician from whom it is difficult to secure the correct information. Reports on the habits of city risks are not generally so reliable as those on risks living in rural districts where any deviations from the accepted standard of conduct are apt to be common knowledge.

In connection with moral hazard, there is a need for careful appraisal of motives, needs, and insurable values. Particularly when special forms are requested, attention should be given to speculation and *overinsurance*. A person is overinsured when the amount of disability indemnity provided by his accident-and-health insurance exceeds his earned income. Theoretically, under these circumstances it is to his pecuniary advantage to be disabled. The applicant's earned income in relation to his type of work should be analyzed. Persons in positions of financial trust but with small incomes may be tempted to "borrow" at the expense of their employer and then be forced to suicide as a way out. Undue regard for health, diet, or living regimen is a clue to impending illness. "Voluntary applicants"—those who apply for insurance without being solicited by an agent—should be checked carefully for an ulterior motive.

¹ JESSIE, O. J., "Tips on Underwriting Accident and Health," *Weekly Underwriter*, Sept. 5, 1936, p. 530.

One of the few definite statements that can be made concerning moral hazard is that it increases with the amount of the indemnity. It is almost axiomatic that the larger the indemnity, the higher the ratio of loss is to premiums. This fact was borne out by the experience of the companies with their "jumbo" risks during the depression. In times of financial adversity, heavy buyers of insurance may be tempted to turn to their insurance as an auxiliary source of income. Even in normal times, the well-to-do or heavily insured policyholder will recover from his disability in a leisurely manner because he can afford to do so.

Two phases of moral hazard, suicide and the use of intoxicating liquors, have been subjected to careful study. The leading causes of suicide are:¹

1. Loss of fortune or reputation; dishonor
2. Ill-health or incurable disease
3. Mental diseases
4. Disappointment in love affairs
5. Minor causes such as sheer boredom, fraud, or crime

From an insurance point of view, suicide is a contingency of no little consequence. On the average, 5 per cent of the death claims paid by life-insurance companies are on policies matured by the known suicide of the policyholder, and an additional 1 per cent are cases involving suspected suicides. In 1932, the percentage of life-insurance suicide claims reached 7 per cent by number and 14 per cent by amount, indicating a correlation between this hazard and the business cycle. The average suicide during the depression was the businessman who had lost his reputation along with his fortune and who could not face his friends in his altered circumstances. Although the life underwriter has the primary interest in suicide, the accident underwriter is also involved; for, although death by suicide cannot reasonably be construed to result through accidental means, not infrequently suicides occur under circumstances which give rise to a claim of accidental death which cannot be effectively disproved.

Statistical studies have been made of the incidence of suicide by nationality, race, sex, and age. Every year in the United States, about 20,000 people kill themselves. Of every 1,000

¹ MUHLBERG, WILLIAM, "Suicide," *The Claim Investigator*, September, 1936, p. 59.

babies born, 10 males and 3 females may be expected eventually to take their own lives.¹ The Metropolitan Life Insurance Company, in its 20-year analysis of experience with industrial policyholders, found for the group studied that proportionately $3\frac{1}{3}$ times as many men as women commit suicide. The ratio increases with advancing age. The rate for white males in the age group 20-24 years was found to be 12.9 suicides per 100,000 policyholders. This rate increased sharply to 63.4 per 100,000 policyholders at ages 65-74. After age 25, the rate of suicide among Negro risks is consistently lower than for whites, running only about one-sixth as heavy at the important older ages. Different nationalities show a wide dispersion along the suicide scale. Austrians lead with 36 suicides per 100,000 population. The Roman Catholic Irish and Spaniards are low, with an average of 3 suicides per 100,000. The United States stands about midway down the scale with 16 suicides per 100,000 population. The city rate is about twice as high as the rural with the unmarried more prone to take their own lives than their married brothers and with the divorced person the worst risk of all. A certain correlation seems to exist between suicide and intellectuality with the professional classes more prone to suicide than manual laborers.² Self-destruction is accomplished in a variety of ways. For 1931-1933, the principal means of suicide were: firearms, 38.4 per cent; poison, 15.9 per cent; poison gas, 13.9 per cent; hanging, 17.6 per cent; drowning, 4.8 per cent; cutting instruments, 4.4 percent; and jumping from high places, 3.3 per cent. Though no study of statistics will pick out for the underwriter the individual risks who will ultimately take their own lives, a knowledge of the incidence of suicides assists in the analysis of the background, habits, motivation, and insurable values upon which the company must depend in judging this phase of the moral hazard.

The repeal of the eighteenth amendment to the Federal constitution brought the liquor hazard squarely to the forefront. Although alcoholic-habit cases were a problem even during the days of Prohibition, since the return of legal liquor there has been

¹ "Mortality from External Causes." *Metropolitan Life Insurance Company Monograph* 3, 1935, p. 17.

² MUHLBERG, *op. cit.*, p. 59.

a sharp increase in the number of cases presented involving the drink hazard. In one year, 1935, the number of risks uninsurable because of excessive use of alcohol increased 13 per cent among people under age 30. For all ages, one company reported an increase of 35 per cent in number of applications rejected because of liquor habits during 1932-1935.¹ The increase in the number of moderate or occasional drinkers has been even more pronounced. The accident underwriter is particularly interested in the effect of drinking upon the automobile hazard. According to one survey, the number of automobile accidents in which one or more of the parties had been drinking has risen by almost 50 per cent since 1932.² The growth of the liquor trade has injected a further complicating factor into underwriting—experience has demonstrated that many persons engaged in occupations connected with legal liquor are not desirable risks.

The elusive nature of precise information on habits makes underwriting of the liquor hazard a ticklish business. It is characteristic of reports on the social drinker that the extent of indulgence is understated and reports on the same risk will vary.³ "Spree drinkers" or free users do not apply for insurance so frequently as the social drinker, and accurate data are more easily secured on the flagrant user. Alcohol-habits cases fall into four divisions. The first, strangely enough, is the total abstainer. In connection with this risk, it is important to know whether he has ever used intoxicating liquors and if so why he stopped their use. Has he received a "cure"? There is a strong presumption in cases showing an abrupt cessation of the use of alcoholic beverages that abstinence is forced because of actual or threatened physical impairment. The results of medical and psychiatric treatment for alcoholism are discouraging, with relapse the rule rather than the exception. Hence, the history of a "cure" is extremely significant. The majority of applicants fall in the second class. They are the moderate, or average, social drinkers. The underwriter must ascertain the extent of his

¹ "The Drink Hazard," *National Underwriter*, May 29, 1936, p. 12.

² HILL, WALTER C., "Insurance Hazards Incident to the Distribution of Liquor," p. 3.

³ MCANDLESS, A. J., "The Underwriting of Alcoholic Habits Cases," *Ounce of Prevention*, December, 1936, p. 1.

applicant's indulgence and how he conducts himself while drinking. The habit, or daily, drinker constitutes the third class and is a dangerous risk. He is liable to be slipping nervously and physically. The fourth type is the spree drinker, also a definitely bad risk. Perhaps in no other phase of underwriting is the need for full and complete information so dramatically apparent as in connection with habits. To keep pace with the increasing risk, the underwriter must develop and perfect his sources of information and exercise constant care and ingenuity in order to differentiate between the standard risk of the normal average drinker and the substandard risk of those who indulge not wisely but too well.

No greater truth can be stated concerning the work of the underwriter than to say that it is not gallstones, goiter, or gout against which he insures. Rather it is the people who have gallstones, goiter, and gout. The underwriter must appraise human nature even more than physical impairment, and human nature does not readily lend itself to calibration. The variables which go into the make-up of character are so numerous as to defy enumeration. One attempt, at least, has been made to devise a method of checking up on the moral hazard. It involves debiting the risk for bad points, crediting it for good ones. Here are some of the factors involved:¹

Debit	Credit
1. Extravagance in living standards	1. Systematically saving on income received
2. Evasion or slow payment of debts	2. Credit A1 at the bank, 30 days at stores
3. Questionable previous disability claims	3. Insurance carried 5 years without company criticism.
4. Agent's loss ratio 10% above company average	4. Agent's loss ratio 10% below company average
5. Applying for \$100 weekly or more	5. Applying for \$50 weekly or less
6. Total insurance exceeding two-thirds of earned income	6. Total insurance less than one-half earned income.
7. Drinking or women or both	7. Active in church work

¹ DINGMAN, H. W., "Personalities in Insurance," p. 15.

Debit	Credit
8. Gambling to excess	8. Active in Red Cross, Y.M.C.A., Masonic or K. of C. work
9. Foreign born	9. American born

As imperfect as the scheme is, it does offer a convenient method of focusing attention upon some of the salient factors affecting the all-important moral hazard.

Another suggestion for rating moral hazard would assign a value of 25 per cent each to morals, habits, personal reputation, and business reputation. To be acceptable for insurance, a risk would be required to have a grade of at least $12\frac{1}{2}$ per cent of the four divisions.¹

Other-insurance Considerations.—Another index to insurability is the applicant's *previous insurance history*. Carrying moderate amounts of life or disability insurance and maintaining a clean record are favorable indications. Past claims should be investigated with the view to determining the nature of the disability and the applicant's attitude in the adjustment of the claims. If the application reveals that the insured already is carrying a line of disability insurance sufficient properly to indemnify him against loss, no further coverage should be granted.

Since disability insurance is an indemnity form of insurance, it is important that the applicant should receive indemnities which are true earnings protection but which are not so large compared with earned income as to encourage malingering. The carriers have set as the maximum limit for which coverage will be granted weekly indemnity equal to 75 or 80 per cent of the applicant's earned income. If the insured has other insurance applicable to the risk, the amount granted will be reduced accordingly. The insured is made a coinsurer to the extent of 20 per cent of his earnings in the hope that malingering will be minimized. With the insured carrying approximately one-fifth of his own risk, it becomes quite as much to his own interests as the insurance carrier's for the disability to be terminated as promptly as possible. The 20 per cent margin is also useful in preventing

¹ "Moral Hazard," *Weekly Underwriter*, Dec. 12, 1936, p. 1347.

overinsurance in the event of wage fluctuations during the term of the policy. In this connection, it is well for the underwriter to keep future earnings as well as present earnings in mind. In view of their experience with jumbo risks, some companies refuse to grant or participate in a line of disability insurance exceeding \$250 or \$300 per week, on the theory that any risk, regardless of income, can carry on with indemnity of that amount and to grant larger benefits would be to encourage the moral hazard.

Occupation.—Closely connected with earnings is the question of *occupation*. Since disability insurance is earnings protection, unemployed persons are ineligible for most forms. The occupational hazard is important principally in accident insurance. The underwriter must have a full description of the duties performed by the applicant in order that he may be classified and rated properly. All companies follow a classification manual in which all occupations are grouped by inherent hazard into several classes, usually 4, 9, or 13 in number. Certain occupations are uninsurable from the accident viewpoint or require special handling. They are those of: acrobats, professional aviators, wild-animal trainers, army and navy men in time of war, professional athletes, automobile racers, caisson workers, chemists manufacturing explosives, circus performers, deep-sea divers, electrical workers dealing with high voltages, explosive handlers, fishermen offshore, horse racers, hunters and trappers, life guards, mining prospectors, crews of ocean-going vessels, steeple jacks, secret-service agents, government investigators, and war correspondents.¹ These risks are not acceptable because the work they do presents such a great degree of hazard that it would be almost impossible to fix a premium for it. Another type of risk, those holding one-man jobs, is not looked upon favorably for the regular forms of policy but may be acceptable for death, dismemberment, and reimbursement coverage. This type includes actors, artists, authors, lecturers, professional dancers, musicians, domestic servants, housewives, capitalists, as well as retired risks and students. If indemnity for loss of time were to be granted these risks, a considerable problem would arise in determining the onset and duration of disability.²

¹ SOPER, *op. cit.*, p. 33.

² "Underwriters Handbook," p. 36.

Susceptibility to disability will vary among different kinds of work. Doctors, dentists, and barbers, for instance, all being dependent in the performance of their daily duties upon the free and unimpaired use of their hands, present a greater risk for the carrier than others subject to nearly the same hazard; for though a slight scratch or trivial hand injury to the average person would occasion no loss, to a doctor, dentist, or barber it might result in an expensive disability.

Persons engaged in work where there is a direct occupational-disease hazard are not considered for health insurance. This applies particularly to painters; subaqueous or caisson laborers; leadworkers; workers in processes involving the use of arsenic, mercury, wood alcohol, aniline dyes, mineral acids, or poisonous gases or the manufacture of chemicals; furriers, tanners, and those in dusty trades—all occupations where unsanitary or unhealthful conditions prevail. In judging the occupational risk, the underwriter has to contend with the seasonal factor in some lines. It is a notorious fact that farmers are usually disabled in the winter time, when their work is light, and teachers during the summer-vacation period. The moral hazard in its relation to occupation must be watched as in the liquor business or where the applicant's office is in his home.

Occupation completes the list of factors for which every risk should be checked. There are, however, certain other situations which the underwriter must bear in mind. Applicants who engage in amateur sports such as polo may require rating up or waiver for injuries sustained while engaged in the sport. The use of a motorcycle for other than pleasure purposes increases the hazard and must be handled accordingly.

Renewals.—The underwriting process does not stop when a risk is accepted and the policy issued. Periodically, there must be a reselection in order to insure the maintenance of a standard group of risks on the books. The practices of carriers vary as to when risks will be reviewed. Whenever a change in the policy is made, the underwriter should recheck the risk. Certain factors such as the amount of indemnity, type of policy, sex, whether the insurance is accident or health or both, the degree of hazard presented by the occupation, and age will all influence the frequency of the review. Generally, when premiums are increased,

benefits reduced, or overage certificates or renewal applications secured, the case should be underwritten again.

At established intervals, annually, biennially, or triennially, depending upon the amount of the insurance, a new inspection report is secured by many companies. After settlement, all claims should be referred to the underwriting department for action. On the basis of the claim, it may be deemed advisable to retire from the risk, endorse the policy, or investigate further as to physical condition, occupation, earnings, or other insurance. All impairment cards or other information received on risks insured by the company should be referred to the underwriter as possibly affecting the current insurability of the policyholder.

The selection process continues without end. The underwriter's task is a difficult and trying, though interesting, one. In his hands rests the success or failure of his company, and to a very great degree the future of accident-and-health insurance. That he has done his job as well as he has is a tribute to the energy and discrimination of the profession.

CHAPTER VII

PREMIUM RATES

It is an interesting commentary upon the rate-making process in accident-and-health insurance that the rate which James G. Batterson computed in 1864 for *level* insurance ("level" insurance provides indemnity in the ratio of \$5 weekly indemnity for each \$1,000 of principal sum) is still the basis on which accident premiums are built. Batterson computed the rate for level insurance at \$5 for every \$1,000 principal sum and \$5 weekly indemnity for select risks. From the time that Batterson made his calculation up to the present, there have been revolutionary changes in the hazard and the benefits. Double, triple, and quadruple indemnity, the accumulation clause, the beneficiary feature, increase in partial-disability benefit, life indemnity for total disability, hospital and surgical benefits, and many frills have been added without any commensurate increase in the premium. In the preferred classes, the rates have remained pretty much undisturbed. Meanwhile, the hazards of modern life have piled up an ever higher toll of accident and disease.¹

Rates have been made by trial and error, their determination being matters of judgment and competition. Individual carriers have utilized their own experience where that was all that was available.² Statistics have been gathered by the companies on the basis of premiums received and losses paid. This system enables a carrier to know whether the whole line is profitable but fails to allocate costs between occupational classes or the various benefits of the policy. It makes the combination of experience of different carriers difficult owing to divergent policies and practices.³ When Batterson set his rate for level insurance

¹ FLYNN, BENEDICT D., "Work of the Statistical Committee of the Bureau," *Proceedings of the Casualty Actuarial and Statistical Society*, Vol. II, p. 228.

² TARBELL, T. F., "Some Observations on Accident and Health Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. XIII, p. 321.

³ KULP, C. A., "Casualty Insurance," p. 575.

in 1864, he fitted the coverage to it—but since 1864, many things have happened which have changed the hazard. Of primary importance has been the increase in automobile accidents. With the advances made by the medical profession, new and expensive types of treatment have raised the cost of medical care. The public and the legal profession have become increasingly insurance-conscious with the result that claims which never were contemplated by the policy have been presented and litigated. The carriers, under pressure of competition, have failed to make adjustments in their rates to allow for these changing conditions. Rather, they have tried to compensate for the growth of the hazard by changing the language of the policy.

The establishment of accident-and-health insurance on a basis comparable with that of life insurance has been impeded by a number of factors besides the lack of comprehensive experience tables. False or fraudulent claims and malingering upset morbidity calculations. Disability insurance suffers from unpredictability of claim duration, for one man may take twice as long as another to recover from the same type of injury. No satisfactory way of measuring the tendency for morbidity to increase with the larger indemnities has been found. Residence, race, physical condition, and occupation are all complicating factors.¹ These variables cause the widest differences in the experience of individual companies and make it difficult to accumulate a uniform experience on which a modern morbidity table might be based. The first published experience on American disability risks, suitable for insurance purposes, was compiled by the Bureau of Personal Accident and Health Underwriters in November, 1929. It covered the commercial experience of several member companies for 1921–1926. In 1931, the Health and Accident Underwriters Conference made its computation of annual net premiums based on statistics covering 35,000 accident and 42,000 sickness risks from 1924 to 1928.

¹ CRAIG, J. D., "The Actuarial Basis for Premiums and Reserves in Personal Accident and Health Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. XVII, p. 50.

HART, V. W. D., "Recent Developments in Commercial Accident and Health Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. XXXI, p. 291.

It was this ignorance of costs which in the early days was responsible for the many restrictions in the coverage and which later, in the era of intense competition, permitted the addition of frill after frill to the policy. The companies knew of these evils in their practice, but during prosperity none could spare the time or attention from the race for production volume to attempt to put its business on a sounder basis. As the years wore on, with competition becoming more intense, benefits more liberal, and underwriting less strict, the loss ratios began to mount. Even before the depression, the profit on accident-and-health insurance was disappearing. The collapse of industry after 1929 had its indirect effect in rapidly increasing loss ratios. Disability insurance became unemployment insurance, and even honest insureds did not recover so rapidly as formerly, having little incentive to return to work. The carriers began reaping the harvest of 30 years of reckless competition. The experience of the underwriters as reflected in the ratios of losses and claim expenses paid to premiums written illustrates how rapidly the crisis developed and how the application of corrective measures has helped restore the business to a normal basis:¹

Year	Stock, companies, %	Mutual companies, %
1930	54.7	81.9
1931	61.8	63.5
1932	66.0	65.7
1933	60.2	64.1
1934	53.0	57.4
1935	48.6	54.3
1936	44.3	49.6
1937	41.8	46.3
1938	43.2	49.1

The Bureau Program.—The careful students and leaders of the business who had for years decried the destructive competition which added frills and liberalized the protection without making adequate provision in the premium rate took advantage of the

¹ *Best's Insurance Reports*, (casualty and surety ed.), 1939, pp. 753 ff.

opportunity presented by the abnormal loss ratios of the depression years to work out a program to bring the carriers together in the interests of better underwriting. The Bureau of Personal Accident and Health Underwriters took the lead in this movement with the result that over 30 of the larger carriers pledged their cooperation, effective Mar. 1, 1932, to a comprehensive plan. This program, which was instituted with the blessing of the National Convention of Insurance Commissioners, included four salient points.¹

1. Companies were to pool their statistics in order to make available the most complete information possible.

2. The Standard Classification Manual which had remained practically unchanged since 1900 was completely overhauled and brought up to date so as to reflect the current hazards of the various occupations.

3. Standardized wording was devised for the insuring clause and the total and partial disability clauses which should not under any circumstances become points of competition thereafter. A degree of uniformity was recommended for the other important clauses in the policy. In order to guide the companies, six advisory forms were drafted. Rates for these forms were computed on the basis of a 50-million-dollar exposure covering the experience of eight companies over the years 1925-1929.

4. All new policies or departures from the advised forms were to be presented to the Bureau for approval and rating by its statistical committee. In this fashion, the Bureau hoped to insure adequacy in the premium rate while permitting the companies sufficient freedom to meet the needs of the business.

The results of the Bureau program have been extremely gratifying. By pooling their statistics, the carriers are building up a background of experience which will be valuable because it comprehends, for the first time in the history of the business, a tremendous number of risks insured under similarly worded policies providing benefits substantially the same as to kind and limitation. The Bureau is now in a position to calculate rates upon a scientific basis. By adopting a uniform wording for important provisions, the companies are not faced so frequently with the

¹ ROGERS, PAUL, *Report of the Governing Committee of the Bureau of Personal Accident and Health Underwriters*, Feb. 1, 1933, p. 4.

necessity of resorting to the courts for judicial interpretation of the language of the policy. Most carriers under the program have reduced the number of policy forms offered with a resultant better understanding of the protection by both the agency organization and the insuring public. The establishment of adequate rates for the new business has permitted the carriers, working together, to adjust the premiums on the old business as it was renewed. Adoption of the standard Bureau Classification of Risks has eliminated price cutting to a large degree. No cooperating carrier is able to quote a more attractive rate than any other. The accumulation of reliable statistical information has made possible the development of modern policy forms on an adequate premium basis. The widespread adoption of the medical-reimbursement form may be attributed to the carriers' confidence in the rates established by the Bureau. All in all, policyholders are being better served, and the business is being conducted on a sounder basis. The Bureau is developing the machinery which should put accident-and-health-insurance underwriting upon a permanently stable basis.¹

Through tabulation of the statistical information furnished the Bureau by its subscribing members, a breakdown of the data can be secured showing the experience of the carriers by policy form, occupational classification, amount of principal sum and weekly indemnity, age, and territory. The distribution of total-and partial-disability claims by length of disability is also determinable. Two methods of summarizing this material are used. The *loss-ratio* method is useful in checking the results of an individual carrier and for comparative purposes. The *pure-premium* basis of summary is more practical. It contemplates obtaining the probability of accidental death and the number of weeks of disability per life per year exposed. From these probabilities, a net rate can be figured.

The carriers associated with the Health and Accident Underwriters Conference have likewise taken constructive steps looking to better underwriting. In 1931, the Conference adopted a code

¹ BOWEN, E. C., "Outlook for Accident Insurance," *National Underwriter*, Mar. 31, 1935, p. 27.

O'CONNOR, E. H., "The Bureau Program," *Weekly Underwriter*, Mar. 28, 1936, p. 656.

of advisory forms in order to encourage a greater uniformity of policy phraseology. A standard classification manual is revised periodically and is available for the guidance of the members. Because of the less homogeneous nature of its membership, the Conference, which includes all types of carriers, has not embarked upon so ambitious or comprehensive a program as the Bureau; but the weight of its influence is being lent to the objectives of the Bureau program. By cooperative effort the carriers are placing the premium computation beyond the vagaries of chance fluctuation or individual bias.

The Statistical Department.—Rate making includes the entire process of determining the price of insurance for an individual risk. Rates must be sufficient to discharge contractual obligations and to render necessary services and must be equitable as between different classes of policyholders. As the law usually states it, they must be “adequate, reasonable, and nondiscriminatory.”¹ Certain practical considerations affect the process. There must be consistency of method. Reasonably flexible rates which are responsive to changes in the business must be produced, but the rates must be fairly stable lest they inspire a lack of confidence.

The rate maker cannot sit down and from pure judgment quote a rate which will meet all these tests. He must have at his command adequate statistics bearing upon the hazard to be assumed. Most of the larger carriers now have well-equipped statistical departments in charge of trained statisticians. Through the use of electrical tabulating machines, the experience of the companies is broken down. It is upon the basis of the raw material furnished by the statistical departments that most rate-making and underwriting-policy decisions are made.

In view of the importance of the work of the statistical department, an understanding of the technique of its operation is essential. As soon as the application is received at the home office, a transcript is made of it and a copy sent to the statistical department. Here the information contained in the application is punched into a tabulating card. The Hollerith or Powers tabulating machines are in standard use with most companies.

¹ MICHELBACHER, G. F., “The Use of Judgment in Ratemaking,” *Spectator*, Dec. 3, 1925, p. 38.

[illegible]

A typical tabulating policy card for premium statistics and accounting.

[illegible]

A tabulating machine claim, or loss, card.

relative to the policy year, occupation, class rating, insured's age and sex, state and city of residence, term of contract, amount, premium, and agency. Any return premium is also punched on this card. The other card is the loss, or claim, card; in addition to some of the identification data contained on the policy card, it carries information relative to the amount of death, dismemberment, or total or partial weekly indemnity, elective, and medical

benefits paid; the period of disability; and the nature of the disability. This statistical record is kept strictly up to date. At any time, the underwriter can secure a breakdown of his company's experience by policy line, occupation, policy feature, age, class and race, agency, or particular type of disability, or from almost any other imaginable angle which he desires. Since 1932, carriers which have subscribed to the rating program of the Bureau of Personal Accident and Health Underwriters have been punching duplicate cards and sending them monthly to the Bureau for combination with the experience of other carriers. The work of the statistical department is by no means so simple and elementary as the foregoing paragraphs would seem to indicate. The department is called upon for a wide variety of information including agency and claim data as well as reserve calculations, in addition to its function in premium-rate computation.

The Classification Manual.—In calculating the premium for an accident or health risk, four principal factors must be considered, assuming that the risk's physical condition is acceptable. These factors are age, sex, occupation, and the benefits promised. For substandard risks, the additional factor of impairment is important.

Over 3,000 occupations have been classified by inherent hazard by the Bureau and Conference. For many years, the standard classification was¹ as shown in the table on page 144.

In the recent revisions the old classification was abandoned. The Bureau companies employ a classification based upon 14 groups designated A, B, C, D*, D, E, F, G, H, I, J, K, L, M. Some companies lump all classes below I in one group under the revised manual. A new class, B, was inserted to care for risks intermediate between the old select and preferred and extra-preferred classes. Risks formerly classified as preferred but upon which the companies' experience had been unfavorable were placed in class B. The better risks rated D were given a D* status.

On May 1, 1931, the Conference issued a revised manual carrying eleven classes designated AA, A, B, C, D, E, F, G, H, I, J.

¹ LAIRD, J. M., "Personal Accident and Health Insurance," *Transactions of the Actuarial Society of America*, Vol. XXIII, p. 368.

Classification	Rates, percentage of standard	Type of occupation included
1. Select and preferred.....	100	Bankers, lawyers, clerks
2. Extra preferred.....	120	Dentists, oculists, music teachers
3. Ordinary.....	170	Barbers, watchmakers, egg candler
4. Medium.....	200	Automobile dealers, bath attendants
5. Special.....	250	Brick layers, farmer owners, masons
6. Hazardous.....	300	Truck drivers, carpenters, sheepherders
7. Extra-hazardous.....	400	Cowboys, farm hands, fire-works exhibitors
8. Perilous	500	Lumberjacks
9. Extra-perilous	600	Wild-animal trainers, explosive manufacturers

These classes were similar in scope to those contained in the Bureau manual. Commercial underwriters generally limited their writings to the first four classes while the quarterly-commercial and industrial companies offered insurance to all classes down to and including class H. At the time the Conference issued its revised manual in 1931, there was considerable discussion of the practicability of a reduction in the number of classes. This discussion culminated in the appointment of a Manual Committee through whose efforts a simplified four-class manual was brought out. This manual was adopted by the Conference and became effective Jan. 1, 1936. The simplified manual contains only 1,380 listings as compared to the 6,200 in the 1931 edition. The reduction was accomplished by the elimination of obsolete listings and the assignment of a blanket class to certain industries which had previously been scheduled in detail.

The proponents of the four-class manual have argued in its behalf that since it is simpler it is less confusing to the public and the agent. By reducing the opportunity for misclassification of risks, it makes for better underwriting. The number of claims requiring proration because of change in occupational classifica-

tion is also reduced correspondingly. Underlying all arguments in favor of the simpler classification is the basic fact that there is no longer the need for so fine a differentiation among risks on the basis of the work hazard. The occupational hazard has been replaced gradually by the public hazard as the underwriter's chief concern. Safety education and better tools and working conditions have held the work risk within reasonable limits; but, owing to the automobile and the greater amount of leisure time enjoyed by nearly all classes, recreational and public accidents have increased. Since these injuries are unrelated to occupation, minute discrimination among risks based solely on occupation is inequitable and unnecessary.

Some companies objected to the elimination of the larger number of classes as penalizing the better risks by placing them in the combined class and therefore making it more difficult to write the select business. Others felt that the Conference lacked the experience necessary to determine proper groupings of occupations and the rates which should be charged for them. The increasing acceptance of the simplified manual, however, would seem to indicate that there are no serious obstacles to its practical application.

The Conference was able to make so radical a reduction in the number of occupations classified because the vast majority of applicants are engaged in a relatively small percentage of the 29,000 different occupations listed by the Federal census bureau. The experience of the Aetna Life Insurance Company is typical of the commercial underwriters. The Aetna's statistics show that only 28 occupations in classes A to D inclusive of the Bureau manual are responsible for 84.81 per cent of the company's volume.¹ The occupations which produce the bulk of the commercial business include architects, automobile dealers, bankers, and bank clerks, buyers, civil engineers, clergymen, clerks (wholesale and retail), commercial traveling men, contractors, dentists, editors, publishers and printers, hotel managers and proprietors, insurance agents and brokers, lawyers, lumber dealers, manufacturers, mechanical engineers, merchants, office clerks and bookkeepers, stenographers, physicians and surgeons,

¹ BIDDLE, LOGAN, "The Accident Insurance Manual," *Weekly Underwriter*, Jan. 25, 1936, p. 24.

public-utilities officers, purchasing agents, real-estate dealers, sales managers, stockbrokers, teachers, and undertakers.

A rough division of risks may be made on an occupational basis between the nonmanual, or white-collar, workers and the manual, or machine, classes. At least three factors determine the class to which an occupation belongs. First is the physical hazard inherent to the occupation. To cite an extreme example, the difference in the risks of a motorcycle policeman and a banker is apparent. Occupations also vary according to the moral hazard presented. There is little physical hazard attendant upon the job of a barkeeper, but experience has demonstrated the existence of a moral hazard for the class as a whole. Certain work presents the hazard of particular injuries. A hand injury for a dentist is a totally disabling accident, whereas for a businessman such an injury would not mean the same loss.¹

The relationship between the classes in the four-class manual and in the revision of 1931 is illustrated by the following table:

1936 Four-class Manual	1931 Ten-class Manual
Class AAA.....	Classes AA, A
Class AA.....	Classes B, C
Class A.....	Classes D, E
Class B.....	Classes F, G, H, I

Important as it is, the manual, regardless of form, should not be considered as a cure-all for every problem of the business. Many factors outside the manual affect the loss ratio. All that can be asked of a manual is that it group risks together accurately, simply, and fairly on the basis of their known hazard. If too many classes are included, expense is multiplied, the agent and public are confused, and the evil of misclassification is increased. If too few classes are provided, the better risks are penalized.

Current Premium Rates, Accident Insurance.—It is estimated that the rate increase which was made by the Bureau companies in 1932 on the basis of their statistical studies approximated 17 per cent. Prior to the increase, the companies were receiving a premium of \$4.33 for level insurance of \$1,000—\$5 in class A. The rate was restored to \$5, an increase of 15 per cent. For unlevel principal-sum insurance, the increase approximated 22

¹ GORDON, H. R., "The Five Class Manual," p. 3.

per cent; for unlevel weekly-indemnity insurance, $11\frac{1}{2}$ per cent. An arithmetic average of these increases, irrespective of the volume in each class, is approximately 17 per cent. Actually, the companies are receiving a 20 per cent or better increase owing to the fact that many risks have been reclassified into a higher rate class through the creation of the new B class. The dismemberment benefits were taken out of the death-benefit section and related to the weekly indemnity. It is customary to penalize unlevel insurance by adding 10 per cent to the rate for the extra amounts of death or weekly-indemnity benefits.

The following table gives the rates for accident insurance charged by one of the leading companies now subscribing to the Bureau program. The amount and cost of each type of benefit is set up for every class. In line with the underwriting practices of the Bureau program, the rates quoted are for policies providing total-disability benefits limited to 52 weeks if the insured is unable to work at his own occupation and continuous thereafter for the duration of the disability if he is unable to engage in any occupation. Partial-disability benefits are limited to 26 weeks at 40 per cent for total disability note.

TABLE OF ACCIDENT-INSURANCE RATES FOR MEN

Coverage	Units	A	B	C	D	E	F	G	H
Death	\$1,000	\$1.55	\$1.75	\$1.90	\$2.15	\$3.15	\$3.90	\$4.65	\$6.15
Total disability	5	2.00	2.60	3.25	4.40	5.15	6.40	7.60	10.15
Medical reim- bursement	500	11.75	14.00	17.25	20.00	26.00	32.00	38.00	49.75
Added units	100	1.05	1.30	1.50	1.75	2.25	2.75	3.25	4.25
Double indemnity	1,000	1.70	1.90	2.05	2.25	3.30	4.05	4.80	6.30
	5	2.35	2.95	3.60	4.80	5.50	6.75	7.95	10.50
Hospital, nurse, and surgical	5	0.35	0.40	0.45	0.50	0.80	1.00	1.20	1.55
Partial disability	5	0.60	0.75	0.90	0.95	1.40	1.70	2.05	2.65

The rates for female risks differ somewhat from those for men. The death-benefit premium per \$1,000 is \$0.95 for class A ranging

to \$3.85 for class H, both lower than the corresponding rates for males. The total-disability rate per \$5 weekly indemnity is \$3.10 for class A, as, against \$2 for men and ranges to \$15.40 for class H, as against \$10.15 for men. The initial \$500 medical-reimbursement cover costs \$12.75 in class A as against \$11.75 for the men. The premiums for additional amounts of medical reimbursement are the same as for males. Partial disability per \$5 weekly indemnity costs \$0.85 for women, \$0.60 for men in class A. These rates reflect the markedly lower accident mortality but higher rate of disability among women.

TABLE OF ACCIDENT-INSURANCE RATES FOR WOMEN

Coverage	Units	A	B	C	D	E	F	G	H
Death	\$1,000	\$0.95	\$0.95	\$1.20	\$1.45	\$1.95	\$2.34	\$3.10	\$3.85
Total disability	5	3.10	3.80	4.60	6.15	7.80	9.30	12.35	15.40
Medical reim- bursement	500	12.75	15.75	18.50	23.25	26.75	35.50	42.75	50.25
Added units	100	1.05	1.10	1.35	1.70	2.25	2.75	3.25	4.25
Double indemnity	1,000	1.00	1.00	1.25	1.50	2.00	2.40	3.15	3.90
	5	3.60	4.30	5.10	6.65	8.30	9.80	12.85	15.90
Hospital, nurse, and surgical	5	0.55	0.65	0.80	1.05	1.25	1.50	1.95	2.45
Partial disability	5	0.85	1.05	1.35	1.80	1.95	2.30	3.05	3.75

A study of the rates presented brings out a number of interesting points. Considering classes A to H (the usual practice of commercial and quarterly-commercial carriers is to decline risks rated lower than H), the rates indicate that the hazard of death does not increase in the same proportion as the hazard of total disability. In class H, the hazard of death is figured as about 435 per cent that in class A; the hazard of total disability, comprehending both frequency and severity, about 507 per cent of that in class A. The cost of medical reimbursement increases with the occupational hazard. The relatively small number of claims for double indemnity is indicated by the slight additional

premium charged for that feature. The carriers' adverse experience with partial disability is reflected in the premium added for that coverage.

Although improvement in general business conditions cannot be discounted, the companies believe that the marked improvement in their experience during the years immediately following the initiation of the Bureau program was due in a large measure to the changes made. The worst defects of the old rates seem to have been corrected; and unless unanticipated shifts in the hazard occur, the rates established in 1932 should be adequate for some time to come. Doubtless, minor refinements will be made in the premium structure as the companies' statistical information becomes more complete. It took some time for the full effect of the altered rate to make itself felt. The revised rates were intended to apply only to new business, but the majority of the Bureau companies have also applied the premiums to outstanding policies as they have been renewed.

The Bureau companies are not the only ones which have faced the problem of rate adjustment. Their action represents the most concerted and scientific effort to get at the root of the trouble. The rate increases which most carriers found necessary were put into effect in 1932 and 1933. No particular plan seems to have been followed, each carrier appearing to have taken the action which its own situation indicated as most likely to produce advantageous results. Many organizations increased the premiums for principal-sum protection. Others systematically reduced the amount of protection offered to a single risk in order to rid themselves of the strikingly unprofitable "jumbo" lines. Some companies attempted to analyze their experience by territory, applying rate differentials where indicated. One company drew a straight line across the map, following the southern boundaries of Utah, Colorado, Kansas and extending east to the Atlantic seaboard. A 25 per cent increase in premium rate was made effective (for both weekly-indemnity and principal-sum benefits) in all states south of the line. Another company raised its rates $12\frac{1}{2}$ per cent in all states where its experience had been bad.¹ These attempts to adjust premiums were more or less spasmodic and, since they depended upon the loss-ratio method of

¹ POWELL, JAMES E., "Our Increasing Loss Ratios," pp. 5-6.

analysis, seldom meant more than patching up the old rate where it seemed particularly deficient. The Bureau's effort, on the other hand, was to reconstruct the rate altogether.

Health Insurance.—Health-insurance rates are somewhat simpler than accident-insurance rates because they are not subject to the same degree of occupational division, nor is there such a multiplicity of benefits. The two chief provisions are those covering loss of time and medical expenses. Full-coverage unallocated medical reimbursement is not granted to any extent for sickness. The hospital, nurse, and surgical schedule form is the type of medical indemnity customarily used. Rates are given below for such a policy, providing total-disability indemnity limited to 52 weeks and a hospital-and-nurse indemnity of not to exceed 50 per cent of the total-disability weekly rate for 20 weeks.

HEALTH-INSURANCE RATES
(Per \$5 weekly indemnity)
Male Risks

Coverage	Class ABCD		Class EFGH	
	Ages 18-49	Ages 50-54	Ages 18-49	Ages 50-54
House confinement required—first day up.....	\$8.00	\$11.00	\$9.00	\$12.00
No house confinement required—14 days eliminated.....	6.50	9.50		
House confinement required—14 days eliminated.	5.50	8.00	*	

Female Risks

Coverage	Office workers		Teachers		Others	
	Ages 18-49	Ages 50-54	Ages 18-49	Ages 50-54	Ages 18-49	Ages 50-54
No house confinement required—14 days eliminated.....	\$9.00	\$13.50	\$13.50	\$20.00	\$18.00	\$27.00
House confinement required—14 days eliminated.	7.50	11.00	11.00	16.00	15.00	22.00

The rates quoted in the foregoing schedule differentiate roughly between risks engaged in the more hazardous and the less hazardous occupations. This distinction is not universally used, for many companies do not consider the occupational factor in computing health-insurance premiums. These rates are higher than the premiums for accident insurance, reflecting the heavier morbidity due to sickness and the greater degree of adverse selection against the company. No discussion of health-insurance rates would be complete, however, which did not recognize that in this particular branch of the business the position of the average multiple-line commercial company is distinctly different from that of the monoline disability company, life carrier, or underwriter specializing in the personal coverages. The health-insurance rates advised by the Bureau give weight to the fact that many of its carriers are not particularly anxious to develop a large volume of health-insurance premiums. A good deal of light is shed upon this attitude when the student understands that a large part of the business underwritten by these companies is developed by brokers and general casualty agents who control the placement of other lines in which the company may be interested. Under the circumstances, the carrier is handicapped in giving direction as to type of prospect solicited. Concentrating, as many of them have, on purely commercial risks, the Bureau companies by and large have not been in so favorable a position as companies writing a quarterly-commercial or industrial business to secure a wide exposure of small risks. Thus both because of the manner in which their health business has originated (it is axiomatic that brokerage business in accident-and-health insurance is less desirable than that produced by the companies' own carefully trained and supervised agents) and because the commercial line has run to jumbo risks, many strictly commercial companies look upon it as an accommodation cover. To discourage the business which they do not want, these companies have set their rates high, particularly for those engaged in the more hazardous occupations. The high rates in turn have intensified the selection against the company, and the loss ratios have mounted. The experience of some companies which operate both commercial and industrial departments is illustrative. These carriers almost without exception have found that health

insurance placed by the commercial department through brokers and general casualty agencies has been consistently less profitable than that written by their own agents in the industrial department, though the commercial premiums were substantially higher for the same amount of indemnity.

The attitude of most carriers which specialize in disability insurance is quite different. They have the facilities for securing a large volume of health-insurance premiums through their own field underwriters without the necessity of accommodating a prospect who is a valued client because of his other lines. They can keep their average exposure per risk low not only because they write largely in a lower income class than the multiple-line carriers, but also because they have a wider field in which to work. Fairly typical of the carriers which are carrying on a satisfactory and aggressive health-insurance business is the experience of one stipulated-premium mutual which has written such insurance for over 20 years. Since 1924, its base rate for a policy providing indemnity for total confining disability limited to 52 weeks, total non-confining disability limited to 10 weeks, and quarantine up to 6 weeks has been \$1 per year per dollar of weekly indemnity. By careful underwriting and holding the amount of protection granted to reasonable limits, this carrier has been able to show consistent progress with premium rates substantially below those of the Bureau.

Elimination Period.—The explanation made above of current premiums charged for accident-and-health insurance does not clarify the differences in some of the premiums. There are a number of distinct problems in connection with the rating process which deserve individual consideration. The first of these has to do with elimination periods.

A *deductible* is used in many insurance lines—a provision excluding from the policy the right to receive benefits for small losses. The terms *elimination period*, *waiting period*, and *excepted period* are used interchangeably to designate a deductible in accident-and-health insurance. The elimination period is not to be confused with the probationary period of 15 or 30 days provided by most health-insurance policies between the date of policy issue and the effective date of the sickness coverage. The probationary period applies in setting the time when the coverage

goes into force, whereas the elimination period or the absence of one determines when benefits begin to accrue in the event of disability, once the policy is in force. Such a provision is in keeping with the mission of most indemnity forms of insurance, viz., to reimburse the insured for the large, unexpected losses which it is hard for him to bear unassisted. To no line can the deductible principle be more easily applied than to personal-disability insurance. By forgoing benefits for a short waiting period, the insured can secure much better protection at a smaller premium rate. The companies are now making use of the waiting period to a considerable extent. Because of the very large number of disabilities which are of but a few days' duration, by making the policyholder a coinsurer through the use of an elimination period the cost of the insurance can be held to a reasonable figure.

The following table, taken from a study of 31,125 health claims and 23,195 accident claims made by the Health and Accident Underwriters Conference in 1927, shows the number of claims terminated at the end of various periods.

CLAIM DURATION*

Number of days' duration	Percentage of all sickness claims terminated	Percentage of all accident claims terminated
3	6.05	3.32
7	32.13	19.58
14	63.37	48.90
21	78.10	66.89
28	84.83	77.31
30	87.79	82.06
60	96.63	96.00
90	98.72	98.48

* *Statistical Report of the Health and Accident Underwriters Conference* (January, 1927) p. 2.

The average loss of time for sickness claims was 17.7 days and for accident claims 21.7 days of disability per claim. Up to the thirtieth day of disability, there is a considerable disparity between the number of accident and sickness claims settled. It is clear that health insurance is particularly subject to a large

volume of small claims and is therefore peculiarly adapted to the use of an elimination period.

A similar study of 118,323 total-disability sickness claims, made by the Bureau of Personal Accident and Health Underwriters, bears out the conclusions drawn from the Conference's investigation. The following is a summary of the Bureau's findings relative to duration of claims.

CLAIM DURATION*	
Number of Days Duration	Percentage of all Claims Terminated
3	6.12
7	32.39
14	63.94
21	77.21
28	84.12
30	85.33
60	94.68
90	97.10

* "Combined Health Experience," *Report of the Committee of Five on Statistics of the Bureau of Personal Accident and Health Underwriters* (1932), p. 143.

A comparison of the two studies reveals how remarkably close the experience of the carriers affiliated with the two groups has been. The Conference companies write chiefly industrial and quarterly-commercial forms, whereas the Bureau experience is with the straight commercial types. Apparently, claim duration follows much the same curve for both classes of business. The number of claims settled on the last day of each week and each month is decidedly greater than the number adjusted on the basis of less than a full week or full month. This phenomenon is attributed to the tendency of the insured to stretch a 4- or 5-day disability into a full week's loss and the practice of claim examiners to round off a loss on the basis of 2 or 3 full weeks rather than 2 or 3 weeks plus an odd day or two. No doubt the deviation is influenced by the fact that the policy states indemnity in terms of weeks or months. It is usual practice to pay in full losses of less than a whole week.

On the basis of its study of claim duration, the Conference prepared tables showing the reduction in premium which could safely be allowed for different waiting periods. In the case of combination policies, it was assumed that 35 per cent of the

premium covered the accident hazard and 65 per cent the health hazard. A safety factor was adopted, in the form of a percentage deduction from the premium discount indicated by the duration study. The safety factor was intended to cover extraordinary fluctuations and errors in the original study.

PERCENTAGE OF PREMIUM REDUCTION ON COMBINATION DISABILITY POLICIES*

Elimination Periods for Sickness Only

Waiting period	Premium reduction (net)	Safety factor
1 week.....	20	4
2 weeks.....	27	11
3 weeks.....	31	14
4 weeks.....	33	17
1 month (30 days).....	34	17
2 months (60 days).....	38	21
3 months (90 days).....	39	23

Waiting Periods for Both Accident and Sickness

Waiting period	Premium reduction (net)	Safety factor
1 week.....	25	9
2 weeks.....	36	20
3 weeks.....	43	26
4 weeks.....	47	30
30 days.....	48	31
60 days.....	54	37
90 days.....	56	39

* *Statistical Report of the Health and Accident Underwriters Conference* (August, 1927), p. 3.

Reduction factors were computed for policies containing the *retroactive* elimination period which will pay indemnity from the first day provided that the disability lasts for 7, 14, or 21 days. Because of the moral hazard involved, the retroactive feature is considered dangerous when applied to the shorter waiting periods. Reductions for the retroactive elimination period are considerably smaller than for the regular elimination period. When

policies provided that total-disability benefits for the first 15 days of disability will be paid at one-half the full weekly rate, reductions of 10 per cent in the accident premium and 15 per cent in the sickness premium may be made.

The deductible should be popular because it permits the insured to carry more nearly adequate coverage for a much lower premium. In spite of this fact, the average policyholder clings to the idea of full first-day-up coverage. Most policyholders feel that their disabilities will be of short duration, and they want them covered. The possibility of a serious, extended disability is hard for them to visualize in connection with themselves. Agents, too, because of the smaller premium involved in the deductible form press the sale of the first-day-up coverage. In spite of these factors, the elimination period is being used more widely than ever before. There are undeniable advantages in its use. The premium is smaller in comparison with the real protection afforded. The companies are spared the cost of handling annoying small claims, with the result that claim departments have more time to devote to the more meritorious cases. The deductible is useful to the underwriter because it permits him to issue coverage at standard rates to risks who would otherwise be unacceptable or require waivers. The larger commercial underwriters regard the elimination period as the salvation of health insurance. The need for its application in accident insurance is not so pressing, and its use accordingly is not so great in that field.

Classification of Health Risks by Occupation.—There is considerable current discussion of the advisability of classifying health risks, like accident risks, upon an occupational basis. Though occupational diseases are of little consequence in writing health insurance (because the coverage is seldom granted to persons exposed to such diseases), yet occupational environment is an important factor in the loss ratios of certain classes. Respiratory diseases and influenza are the cause of over one-half the loss of time under health policies. Since some conditions of work enhance the possibilities of catching colds and influenza, they have a bearing upon health underwriting.¹ The following table

¹ *Statistical Report of the Health and Accident Underwriters Conference* (October, 1937), p. 1.

shows the experience of the Conference companies covering over 368,000 months of exposure.

HEALTH LOSSES BY OCCUPATIONAL CLASSES*

Class	Number of months of exposure	Average number of days of confining sickness per risk per annum	Average number of days of non-confining sickness per risk per annum
AA	89,991	2.5032	0.8712
A	58,345	2.9472	1.2252
B	61,389	2.4948	0.8412
C	55,483	2.5752	1.1508
D	70,866	2.3436	1.1484
E	28,354	2.6280	1.2324
F	344	1.4304	4.0116
X	3,349	2.1960	1.1400
XX	479	3.3564	2.1048
All classes	368,600	2.5596	1.0524

* *Statistical Report of the Health and Accident Underwriters Conference* (October, 1937) p. 2.

No definite correlation seems to exist between the occupational-accident and -sickness hazards. A rough division might be made between the first four and the last five classes. The less hazardous accident classes are apparently subject to greater sickness loss. A more successful attack on the problem was made by the Conference when it analyzed the sickness losses by specific occupation. Assuming the average loss to be 2.56 days total-confining and 1.05 total-nonconfining disability, a careful study indicates that the following occupations have decidedly high rates of disability: garage employees, clergymen, dentists, foundry workers, gas- and oil-well employees, insurance agents, common laborers, laundry workers, machinists, masons, clerks, nurses, physicians, policemen, railway workers, stenographers, waiters, barbers, and janitors.¹ This study was borne out in its main conclusions by the analysis of 118,000 claims made by the Bureau.² The greatest variation in loss ratios and rates of morbidity was found among the various occupations. It is argued

¹ *Statistical Report of the Health and Accident Underwriters Conference* (December, 1927), p. 2.

² See p. 154.

that unskilled and manual workers are subject to greater morbidity because of sickness due to poorer diet and housing conditions, inadequate medical care, and greater contact with infected cases. To a degree, this argument may be offset by the fact that persons engaged in the more lucrative occupations are in a position to indulge their ailments and recover in a leisurely manner. No discernible correlation exists between the accident and health hazards. The future will no doubt see the formation of a health-classification manual. Its use would undeniably improve the accuracy of health-insurance rating.

The Age Factor.—Various studies that have been made do not show any marked increase in losses at the older ages. The companies usually charge an increased premium for health insurance after age 50 and for accident insurance after age 55 or 60. The accompanying tables, which are representative of the studies made, do not entirely bear out the carriers' practice. An authoritative tabulation of wide exposure to accident claims is now being prepared by the Bureau. It may throw further light on the age factor. The following table is taken from a report by the Conference. It covers $2\frac{1}{2}$ million months of exposure on policies providing coverage not exceeding 24 months' total-disability, and limited to 6 months' partial-disability, indemnity.

ACCIDENT EXPERIENCE BY AGE*

Age	Number of months of exposure	Average number of days of total disability per risk per annum	Average number of days of partial disability per risk per annum
Under 20.....	41,400	1.829	0.704
20-24.....	187,529	1.702	0.957
25-29.....	351,478	1.238	0.772
30-34.....	406,507	1.079	0.799
35-39.....	420,385	0.966	0.783
40-44.....	368,873	0.991	0.928
45-49.....	310,732	1.064	1.009
50-54.....	242,765	1.144	0.978
55-59.....	156,226	1.228	1.061
60 and over.....	71,513	1.161	1.117
All ages.....	2,557,408	1.143	0.889

* *Statistical Report of the Health and Accident Underwriters Conference* (June, 1927), p. 4.

No particular trend appears. Apparently the safest years from the standpoint of the accident hazard are from 35 to 45. Both before and after that time, the loss is greater. It is possible to detect a distinct correlation between age and accidental death. The following figures shed considerable light on this phase of the age problem of disability-insurance underwriting.

MORTALITY FROM EXTERNAL CAUSES BY AGE GROUPS*

(Metropolitan Life industrial policyholders averages of annual death rates per 100,000, white males only)

Ages	Suicides	Homicides	Accidental and unspecified violence
15-19	3.9	4.0	82.1
20-24	12.9	9.0	98.3
25-34	20.1	11.8	89.8
35-44	31.2	11.1	114.5
45-54	43.5	9.3	165.8
55-64	56.5	6.6	230.3
65-74	63.4	4.6	313.8

* "Mortality from External Causes," *Metropolitan Life Insurance Company, Monograph* 3 (1935), pp. 19, 34, 46.

It is noteworthy that the rate of deaths at ages 65 to 74 due to accidents and unspecified violence is more than three times as great as for ages 20 to 24.

Deaths in motor-vehicle accidents show a markedly heavier incidence at the older ages. In 1935, the age group 25-64 showed 34.3 deaths from all causes per 100,000 population as compared with a motor-vehicle fatality rate of 79.4 per 100,000 population over 65 years of age.¹

The Bureau has made an extensive breakdown of health experience in connection with its study of 118,000 claims. The table on page 160 shows a more definite increase in incidence of sickness with age, than was shown for accidents by the Conference's study.

This tabulation reveals that risks for ages 30 to 49 offer the best experience. The increase in the rate of morbidity is very marked over age 50.

¹ "Accident Facts" (1936), pp. 28-29.

SICKNESS RATES BY AGE GROUPS*
(Policy limited to 52 weeks confining total disability)

Age	Years of exposure	Average number of weeks' disability per year of exposure	
		Total	Partial
Up to 20.....	1,226	0.68	0.09
20-24.....	11,516	0.83	0.13
25-29.....	20,371	0.74	0.16
30-34.....	47,781	0.74	0.18
35-39.....	56,591	0.66	0.19
40-44.....	55,516	0.66	0.19
45-49.....	46,825	0.66	0.20
50-54.....	29,928	0.83	0.24
55-59.....	15,032	0.94	0.28
60-65.....	2,053	1.20	0.36
65 and over.....	80	1.33	0.26
Total ages under 50.....	249,826	0.69	0.19
Total ages over 50.....	47,093	0.88	0.26
Grand total.....	296,919	0.72	0.20

* "Combined Health Experience," *Report of the Committee of Five on Statistics of the Bureau of Personal Accident and Health Underwriters* (1932), p. 12.

That the experience of the individual carriers is not necessarily the same as the composite experience is shown by the tabulation of loss by age groups reported by one of the largest monoline insurers, as shown in the table at the top of page 161.

The distinct increase in losses at the higher ages reflected by this experience would seem to justify the practice of the carriers in charging higher rates at those ages. The sharply increased ratio for ages over 65 is especially noticeable.

The Geographical Factor.—Studies of the influence of location are of interest, but as yet the conclusions it has been possible to draw from them have not been given general application in rate making. The summaries of the Conference tabulation of accident rates by states and the Bureau's similar investigation of sickness rates exhibit general differences in the incidence of disability, as shown in the table at the bottom of page 161.

This breakdown indicates that the Western states are the most hazardous. California is highest among all states with a rate of

ACCIDENT-AND-HEALTH LOSS RATIOS BY AGE*
(Premiums written to losses paid)

Age groups	Percentage of premiums in each group to total premiums	Ratios of claims paid to total premiums, accident and health combined
19 and under....	1	48
20-24.....	6	58
25-29.....	11	55
30-34.....	13	58
35-39.....	15	60
40-44.....	15	62
45-49.....	13	57
50-54.....	12	65
55-59.....	9	72
60-64.....	4	78
65-69..... }	1	118
70 and over.... }		
	100	

* "Experience of Mutual Benefit Health and Accident Association," *Health and Accident Underwriters Conference, News Bulletin*, No. 13, p. 5, 1934.

2.16 days' total disability per exposure per annum; Indiana is the lowest with a rate of 0.766. California's rate was principally influenced by its high automobile-accident rate.

The chief conclusion which can be drawn from the Bureau's table is that the Southern states present the highest rate of disability. The experience in foreign countries is not significant,

RATE OF ACCIDENT DISABILITY BY STATE GROUPS*

Area	Months exposed	Average number of days' total disability per annum per risk	Average number of days' partial disability per annum per risk
Northeastern states...	111,873	1.243	0.329
North Central states...	905,829	1.279	0.594
Southern states.....	192,929	1.255	0.527
Western states.....	234,283	1.867	0.475
All states.....	1,444,914	1.368	0.545

* *Statistical Report of the Health and Accident Underwriters Conference* (July, 1927), p. 3.

since most policies do not cover disability suffered while outside the United States or Canada.

RATES OF SICKNESS DISABILITY BY STATE GROUPS*

State group	Years' exposure	Average number of weeks' disability per year of exposure	
		Total	Partial
Northeastern states.....	329,232	0.66	0.15
Middle northern states.....	213,950	0.63	0.17
Central states.....	130,668	0.66	0.15
Southern states.....	85,787	0.69	0.17
Western states.....	94,344	0.66	0.16
Foreign countries.....	25,278	0.71	0.16
All locations.....	879,259	0.66	0.16

* "Combined Health Experience," Report of the Committee of Five on Statistics of the Bureau of Personal Accident and Health Underwriters (1932), p. 45.

Disability-insurance experience by states may also be analyzed by the loss-ratio method. It is a fair assumption that a state which consistently, year in and year out, shows a higher-than-average loss ratio will present some peculiar underwriting factor.

The table on page 163 is an arrangement of loss ratios by states for the business as a whole. It covers the 7-year period 1930-1936 when the country entered, suffered, and convalesced from its most disastrous business depression.

This tabulation illustrates the long-recognized relation between business conditions and loss ratios. The ratios for 1932 and 1933, the blackest years of the depression, are the worst for almost every state. The District of Columbia which was not depressed by the business conditions prevalent in other sections has a splendid record for the entire period. As a section, the New England states, long settled and stable, make the best showing. In interpreting geographical differences in experience, a number of factors must be considered. The attitude of the courts in construing the policy contract, particularly in interpreting and applying the clauses relating to total disability, partial disability, and nonconfining total disability, is significant. There is the

LOSS RATIOS BY STATES*

Losses paid to premiums written. Accident and health (including non-cancelable) combined

State	1930	1931	1932	1933	1934	1935	1936
Alabama.....	0.59	0.72	0.77	0.71	0.64	0.60	0.55
Arizona.....	0.52	0.73	0.71	0.74	0.73	0.74	0.64
Arkansas.....	0.70	0.78	0.67	0.72	0.70	0.59	0.59
California.....	0.44	0.63	0.61	0.60	0.60	0.56	0.50
Colorado.....	0.47	0.52	0.65	0.70	0.63	0.57	0.56
Connecticut.....	0.47	0.48	0.53	0.51	0.57	0.46	0.45
Delaware.....	0.51	0.53	0.53	0.52	0.52	0.51	0.57
District of Columbia.....	0.37	0.45	0.37	0.42	0.41	0.43	0.40
Florida.....	0.57	0.78	0.77	0.70	0.70	0.62	0.58
Georgia.....	0.60	0.58	0.64	0.67	0.59	0.58	0.59
Idaho.....	0.57	0.62	0.62	0.60	0.52	0.58	0.46
Illinois.....	0.52	0.56	0.65	0.61	0.56	0.54	0.53
Indiana.....	0.62	0.62	0.62	0.60	0.55	0.52	0.51
Iowa.....	0.57	0.65	0.69	0.67	0.54	0.52	0.56
Kansas.....	0.56	0.59	0.71	0.67	0.50	0.54	0.52
Kentucky.....	0.52	0.64	0.73	0.64	0.52	0.50	0.51
Louisiana.....	0.53	0.58	0.63	0.56	0.47	0.47	0.57
Maine.....	0.50	0.58	0.56	0.54	0.53	0.52	0.53
Maryland.....	0.53	0.59	0.57	0.57	0.52	0.50	0.47
Massachusetts.....	0.46	0.53	0.54	0.51	0.47	0.45	0.45
Michigan.....	0.58	0.59	0.69	0.60	0.56	0.56	0.55
Minnesota.....	0.52	0.52	0.61	0.62	0.54	0.55	0.52
Mississippi.....	0.64	0.66	0.91	0.78	0.63	0.64	0.66
Missouri.....	0.58	0.60	0.63	0.63	0.56	0.57	0.53
Montana.....	0.59	0.67	0.67	0.67	0.64	0.57	0.51
Nebraska.....	0.57	0.46	0.81	0.73	0.58	0.62	0.58
Nevada.....	0.62	0.60	0.65	0.63	0.62	0.59	0.44
New Hampshire.....	0.42	0.45	0.46	0.52	0.54	0.45	0.41
New Jersey.....	0.42	0.54	0.56	0.53	0.44	0.43	0.41
New Mexico.....	0.42	0.66	0.67	0.62	0.53	0.58	0.57
New York.....	0.51	0.57	0.60	0.61	0.56	0.51	0.49
North Carolina.....	0.51	0.78	0.84	0.76	0.67	0.64	0.57
North Dakota.....	0.60	0.66	0.65	0.71	0.52	0.54	0.57
Ohio.....	0.49	0.55	0.62	0.57	0.51	0.51	0.49
Oklahoma.....	0.60	0.63	0.70	0.73	0.59	0.61	0.52
Oregon.....	0.68	0.75	0.74	0.77	0.67	0.67	0.60
Pennsylvania.....	0.47	0.54	0.54	0.54	0.50	0.47	0.44
Rhode Island.....	0.51	0.54	0.55	0.58	0.49	0.47	0.44
South Carolina.....	0.66	0.80	0.92	1.12	0.67	0.59	0.61
South Dakota.....	0.63	0.44	0.79	0.67	0.56	0.52	0.57
Tennessee.....	0.54	0.57	0.63	0.53	0.49	0.54	0.52
Texas.....	0.59	0.57	0.66	0.72	0.57	0.55	0.51
Utah.....	0.57	0.74	0.72	0.67	0.47	0.53	0.57
Vermont.....	0.47	0.50	0.60	0.56	0.49	0.50	0.44
Virginia.....	0.63	0.65	0.68	0.67	0.58	0.53	0.51
Washington.....	0.60	0.48	0.70	0.66	0.57	0.56	0.51
West Virginia.....	0.61	0.74	0.79	0.70	0.62	0.61	0.56
Wisconsin.....	0.46	0.54	0.60	0.62	0.49	0.50	0.46
Wyoming.....	0.55	0.59	0.53	0.58	0.61	0.62	0.53

* *The Insurance Year Book* (1937 casualty ed.), pp. 10 ff.

widest variance in statutory requirements. For instance, the Missouri suicide law declares that suicide while insane is an accident.¹ Some states permit the insured an unreasonably long time to give notice of disability or file suit under the policy. South Carolina and Missouri have laws assessing penalties and attorneys' fees for vexatious delay. The local economy is important, for wide seasonal and cyclical unemployment plays havoc with underwriting results. Literacy is an important index to health standards, for "Literacy is a gauge of the appreciation the inhabitants have for knowledge. Not only that, it shows the initiative in making systematic schooling provision so knowledge can be obtained by all. Knowledge it is that allows recognition of sanitary and other conditions affecting morbidity and mortality."² The bad experience in the Southern states is attributable not so much to habitat as to the greater illiteracy and lesser prosperity of the region.

For the present, until a greater volume of credible statistics can be compiled to indicate with some reliability the reasons for sectional variations, the carriers are hardly warranted in making sweeping premium readjustments to give specific weight to the geographical location of the risk. In the future, when these data are available, a state differential may be introduced as is done in some of the other casualty lines.

The Automobile Hazard.—Perhaps no single factor in accident underwriting has given the underwriters more nightmares than the increasing loss due to the automobile. This single factor, almost alone, has raised the carriers' loss ratios in spite of a decrease among some classes of occupational accidents. The automobile hazard has changed much of the complexion of accident rating. It has relegated the work hazard to a position of secondary importance and has served to concentrate attention on the public hazard to which all classes are exposed.

Even a cursory survey of the statistics bearing upon the automobile hazard proves that the concern of the underwriters is well founded. This hazard became a considerable factor in underwriting about 1909, when accidents to occupants of automobiles

¹ MANZELMANN, GEORGE, "Rates and Geography," p. 4.

² DINGMAN, H. W., quoted by C. M. Herron, "Mortality In the South," *The Claim Investigator*, November, 1936, p. 2.

contributed 11.4 per cent of the amount of claims paid. This ratio rose to 14.1 per cent in 1910 and 21.8 per cent in 1911.¹ The automobile was then the plaything of preferred risks. This hazard quickly began to turn what had been a profitable classification into a most unprofitable one.

The following table gives the accident-death rate from automobile accidents in comparison with the rate from all causes.

ACCIDENTAL-DEATH RATES,* 1913-1937
(Per 100,000 population)

Year	All accidents		Automobile accidents	
	Number	Rate	Number	Rate
1913	82,460	85.5	4,227	4.4
1918	85,149	82.2	10,923	10.4
1923	84,528	75.8	18,394	16.5
1928	95,186	79.4	27,996	23.3
1929	98,258	80.9	31,215	25.7
1930	99,300	80.6	32,929	26.7
1931	97,415	78.5	33,675	27.1
1932	89,167	71.3	29,451	23.6
1933	91,087	72.4	31,363	24.9
1934	101,139	79.9	36,101	28.5
1935	99,967	78.4	36,023	28.4
1936	110,248	85.8	37,500	29.2
1937	106,000	82.0	39,700	30.7
1938	94,000	72.2	32,400	24.9

* "Accident Facts."

The automobile death rate, increasingly serious as it has become, is only a part of the story. The loss from nonfatal accidental injuries far exceeds the toll of automobile fatalities. In 1938, there were 35 injuries for every death. Automobile casualties were estimated at 32,400 deaths, 1,150,000 injuries, and to have caused an economic loss of \$1,500,000,000. As would be expected, the great bulk of these injuries were sustained by

¹ PAGE, B. A., "Accident and Health Insurance," in "The Travelers," p. 45.

persons of insurable age. The following tabulation shows the distribution of motor-vehicle accidents by age groups.

MOTOR-VEHICLE ACCIDENTS BY AGE GROUPS*

Age	Injuries, %	Deaths, %
0- 4.....	4.7	6.2
5-14.....	18.5	16.4
15-54.....	67.7	54.9
Over 55.....	9.1	22.5

* "Worse Than War." "Smash Hits."

The very serious effect which these rates are having on the amount and distribution of accident claims has been the subject of considerable investigation. One common conclusion which underwriters have drawn from these studies is that not only have automobile accidents produced a greater volume of claims but they have served to raise the average cost per claim. Since the automobile toll became heavy, the artificial-limb business has tripled its volume. The automobile more than any other one factor has played havoc with the select-and-preferred risks who have the leisure and means to spend the most time in the automobile. Typical is the experience of carriers affiliated with the International Federation of Commercial Travelers which insure only commercial risks. In 1916, these associations suffered one automobile fatality per 1,997 members. In 1930, the ratio was one death per 1,203 members. The growth of the public hazard

FREQUENCY AND COST OF ACCIDENTS,* 1928-1933

Type	Number	Amount
Automobiles.....	32,613	\$8,839,500.58
Home.....	31,110	3,733,168.08
Pedestrians.....	13,222	1,564,952.40
Sports and recreation.....	22,967	3,194,754.14
Travel.....	4,468	1,042,196.68
Miscellaneous.....	4,296	1,129,572.53
Occupational.....	26,802	2,964,407.87
Total.....	135,478	\$22,468,552.28

* Experience of the Travelers Insurance Company.

has made the old select-and-preferred risks less choice and is largely responsible for the Conference's reduction in the number of classes in its 1936 Manual.

An analysis of some 135,000 paid accident claims amounting to \$22,468,000 reveals clearly that automobile injuries comprise the largest and most expensive class of claims.

Of the foreign-to-occupation hazards to which everyone is exposed, the automobile accounts for 30.01 per cent of the claims by volume and 45.32 per cent by amount.

The experience in 1932 when automobile deaths fell to 29,500 encouraged some underwriters in the belief that the automobile-disability curve was about to descend or at least to flatten out. The introduction of safety devices such as four-wheel brakes, shatterproof glass, and punctureproof tires, together with improved highways, the safety campaigns (especially among the young), and increasing adaptation to the automobile age, are all hopeful changes in the right direction. There appears, however, to be little reason to feel sanguine over the immediate prospect of any real betterment in the situation. Cars are being built to go faster than ever; the drunken-driver problem is more serious; the highway-improvement campaign is far from completed; the results of traffic safety education are becoming apparent only gradually. As might have been anticipated in 1932, as the depression waned more cars were put on the road with an almost inevitable increase in the number of casualties.

For years, many underwriters have prophesied that a solution to the automobile problem was "just around the corner." As early as 1915, as able an insurance man as B. A. Page said,

The view that this particular hazard [the automobile] has reached its zenith and will subside or at least remain stationary is a reasonable one. Motor cars as now constructed are nearly mechanically perfect. The owner driver is no longer required to be an expert mechanic. The invention and adoption of the self-starter is materially reducing the danger of fractured bones and fatal injuries caused by cranking accidents. Laws governing vehicular traffic are better understood by driver and public alike.¹

All of this only goes to prove that hindsight is better than foresight.

¹ PAGE, B. A., "Accident Underwriting," in "Insurance Lectures," p. 37,

Apparently the underwriters have been able to devise no adequate means of offsetting the hazard. It is one which is inherent in the business. In the early days, a rider was attached to the policy at an extra premium of 40 per cent to cover automobile accidents.¹ The present universality of the hazard makes it imperative that the coverage be included in the regular policies. In addition, special limited covers have been advanced at nominal premiums to indemnify against automobile injury. Rate makers will continue to study the motor-vehicle hazard because it constitutes one of the principal shifting factors which underlie any accident-rate computation. If by encouraging safety campaigns, which today appear to be the most hopeful preventive activity, the carriers can reduce or stabilize their automobile losses, they will have solved one of their biggest problems and will have traveled a little nearer the goal of stable rates.

The Aviation Hazard.—When aviation first came into prominence, it was decided that the danger of injury was too great and the number of risks to be insured too small to warrant granting accident-insurance coverage. After the war, however, commercial aviation made such strides that for several years the leading carriers have been willing to endorse the policy or include in the coverage a clause permitting travel on regular passenger airplanes operated by licensed companies over regular routes between definitely established terminals. No added premium is asked for the endorsement. The carriers have made increasingly liberal provision for persons occupationally connected with aviation although the cost of the insurance is still rather high. In 1936 and 1937, the *private-fliers'* policy, the *Airsurance* forms, and the *aviation-trip* policies² were brought out. The aviation-trip policies, which provide \$5,000 accidental-death-and-dismemberment benefits at a premium of only 25 cents for each 4 hours of scheduled flying, are an indication of the manner in which the accident carriers have kept pace with the progress of aviation.

In selecting and rating aviation risks, the utmost attention must be paid to the individual applicant because of the wide variety of hazards. It makes considerable difference whether the applicant is a successful businessman who may be expected

¹ *Ibid.*, p. 38.

² See Chap. IV.

to exercise mature judgment about how and when to fly or a young aviation enthusiast of unlimited means. Experience differs for pilots, copilots, students, fare-paying passengers on scheduled air lines, passengers on nonscheduled flights, and army and navy aviators. As might be expected, the mortality rate for fare-paying passengers on scheduled air lines has been the best. For the years 1927-1929, the passenger-fatality rate was 147 per 1,000,000 flights; this ratio fell to 45 passenger deaths per 1,000,000 flights for the years 1930-1934.¹ On Mar. 26, 1940, the aviation industry celebrated the completion of a full year without a single fatality or serious injury among passengers or crew on scheduled airliners. The probability that a passenger on a regular, licensed transport ship will meet death by accident on a given trip is only about 1 in 25,000. On the average, there are now approximately $1\frac{1}{2}$ passenger fatalities for each 100,000 passenger hours flown. Thus, a group of policyholders who travel 100 hours a year on air lines will show death-claim cost of about \$1.50 per \$1,000 of insurance because of air-transport accidents. This amount is practically all extra cost to the company since the normal probability of a businessman meeting an accidental death in any given 100-hour stretch would be represented by only about 1 cent per \$1,000 insured.²

The mortality among risks connected with aviation as pilots or government fliers has been considerably heavier. The recent death rate for airport and air-taxi fliers has been eight casualties for each 100,000 hours flown. A pilot flying 300 hours per year would have to contribute \$24 per \$1,000 of insurance owned to cover the added hazard of his work. Since nearly all aviation claims are death losses, the approach used by the life companies insuring aviation risks is of interest to accident underwriters. The table on page 170 gives the schedule of rates and limits employed by a prominent reinsurance carrier.

Very largely, the rating of aviation risks has been left to groups of specialists such as the Associated Aviation Underwriters who represent several of the larger underwriters. These firms are technically qualified to rate the hazards incident to a particular

¹ DUBLIN, LOUIS I., AND ALFRED J. LOTKA, "Length of Life," p. 97.

² HOSKINS, J. E., "Air Risks Mortality Costs," *National Underwriter*, Dec. 20, 1935, p. 1.

RATES FOR AVIATION RISKS*

Number of flights per year	Limit of insurance	Rate per \$1,000
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A. Passengers on regular air lines

1- 20	\$50,000	Standard
21- 40	30,000	Standard
41- 70	25,000	Standard
71- 90	20,000	Standard
91-100	15,000	Standard
Over 100	10,000	Standard

B. Executives using company planes on established air routes

1- 20	30,000	Standard
21- 40	25,000	\$2.50 extra
41- 70	20,000	5.00 extra
71- 90	20,000	5.00 extra
91-100	15,000	7.50 extra
Over 100	Facultative	Facultative

C. Private owner using licensed plane and pilot

1-10	25,000	Standard
11-20	25,000	2.50 extra
21-30	20,000	5.00 extra
31-40	15,000	7.50 extra
41-60	15,000	10.00 extra
Over 60	Facultative	Facultative

* "Aviation Reinsurance Rates," *National Underwriter*, Dec. 20, 1935, p. 1.

risk. For some time, they have compiled experience on aviation insurance and are organized to inspect the equipment of air lines or private fliers. The specialist is in a position to determine the aviation hazard which varies so widely and apply the cardinal insurance principle that all risks exposed to the same hazard should share in the cost of that hazard.¹ Although sometimes in the past the carriers have regretted the generous impulse which prompted them to grant the aviation rider at no added charge, the hazard is a decreasing one, and their experience has

¹ SHEPARD, PEARCE, "Inspections and Aviation," *Inspection News*, Vol. XXII, No. 7, p. 1.

not been bad. Underwriters generally do not fear the aviation hazard but they are awake to its future potentialities.

Lapsation and Cancellation.—The fiercely competitive nature of the accident-and-health-insurance business in the past served to center most of the underwriter's and sales manager's attention upon the acquisition of new business. Too often the problem of keeping the business on the books once it was placed there was entirely neglected. As a natural result, the lapsation in accident-and-health insurance has been extremely high. It was pointed out some years ago that the reasons for the past heavy turnover were: (1) The coverage was frequently taken with little regard for the applicant's real need. (2) The insured had little equity in the policy and could easily replace it with another. (3) The salesman felt he had a vested interest in the business and would switch it if he changed companies. (4) New policies were brought out with such rapidity as to encourage change.¹ A fifth reason might be added. The yearly-term nature of the coverage permitted agents of rival companies to solicit the insured as his policy was about to expire without fear of being charged with twisting.² Happily, much of this situation has changed as the insuring public has been educated to a better appreciation of disability insurance as income protection and the agent has attempted to fit the coverage to the particular personal needs of the applicant. When the proper policy has been placed and the insured understands the nature of the coverage, there is little incentive to change. The more stable condition of the business with the increased emphasis which is being placed on careful selection and training of agents has reduced the turnover among salesmen. There are fewer and better types of policies issued today; hence, much of the old switching from carrier to carrier to gain the advantage of a new policy frill is a thing of the past. The conservationist's chief worry is the policyholder who is forced to allow his insurance to lapse because of lack of funds to pay the premium.

Monthly-premium industrial and quarterly-commercial policies are more subject to lapsation than the commercial business upon which an annual premium is paid in advance. The *lapse*

¹ LAIRD, *op. cit.*, p. 378.

² KNIGHT, C. K., "Advanced Life Insurance," p. 363.

ratio (the proportion of premiums which do not renew to the total amount of premiums exposed to renewal) for the annual forms is about one-half that of the other forms. The commercial underwriters report a normal lapse ratio of 10 to 12 per cent. The industrial companies average nearer 20 to 25 per cent. During the business depression following 1929, lapsation was nearly double the normal ratio, illustrating the close correlation of disability-insurance with the business cycle. One student of the subject has said that for a large number of industrial companies the lapse ratio for new business reached 45 per cent during 1931 and 1932.¹ For the commercial carriers, ratios of 15 and 20 per cent were not uncommon in those years.

Heavy lapsation exerts an extremely debilitating effect upon the carrier, an effect which is especially apparent during hard times when new business cannot be easily secured. During normal times, quarterly-premium commercial policies show a lapse of 25 per cent the first quarter, 10 per cent the second, 8 per cent the third, 7 per cent the fourth, 6 per cent the fifth, and about 4 per cent per quarter thereafter. For 1,000 such policies, assuming an average quarterly premium of \$10, the carrier would receive in 10 years a premium income of \$140,250. If the lapse ratio be doubled, in the 10-year period, the carrier would receive only \$54,650.² In other words, doubling of the lapse ratio means a reduction in premium of nearly two-thirds. Add to this premium loss the expenses incident to repeated attempts to reinstate the policy and home-office and agency expense in handling the policy for a short time, and the cost of lapsation mounts very high.

Lapsation can be cut by proper selection and rating of the risk. If the coverage adequately meets the needs of the insured and is available to him at a reasonable premium, losses will be cut. The usual conservation methods, by means of personal-agency reselling and by direct mail, are not the immediate concern of the underwriter; but the success of the conservation department in keeping the business in force exerts a major influence upon rates.

The *cancellation clause* is a safeguard upon which the underwriter can fall back if the risk which he has accepted proves to be

¹ POWELL, *op. cit.*, p. 6.

² *Ibid.*, p. 7.

other than he had anticipated. Some opponents of the cancelable cover charge, not entirely without justification, that the policy may be withdrawn just at the time when the insured needs it most. Acknowledging the element of truth in this statement, it must be remembered that the cancellation clause is common to nearly all types of casualty covers. It is not the company's intention to offer noncancelable protection under the commercial form, and the premium is computed accordingly. Cancellations for health insurance range about 1 to 2 per cent a year; for accident insurance under 1 per cent. By discharging its obligation under the policy and withdrawing from the risk in even so small a percentage of cases, it is possible for the company to effect a considerable saving in indemnity which is passed on to the policyholders in the form of lower premiums. The principal causes for cancellation are: (1) misstatement in the original application, (2) impaired physical condition, (3) material reduction in the earnings of the insured, (4) repeated claims for recurrent injuries or disease, (5) bad moral hazard.¹

Noncancelable-insurance companies have not yet found a satisfactory way to underwrite all the diverse kinds of risks who look to disability insurance for protection. For this reason and because cancellations do not constitute a major problem, there seems no reason to believe that the cancellation clause will be omitted from the usual form of contract.

Hospital and Medical Benefits.—The benefits provided to reimburse the insured for hospital and medical expenses fall into three groups: (1) a simple percentage increase in the amount of the weekly total-disability benefit; (2) an allocated reimbursement providing benefits for hospital room, surgical-operation fees, and miscellaneous expense items; (3) an unallocated blanket coverage of all expense of treatment subject to a maximum limit.²

In rating the first type of clause, the companies generally follow the conservative rule of thumb that each risk, on the average, will experience one day of hospitalization per year. If a 100 per cent increase in weekly indemnity for 10 weeks is to be made for hospitalization in a policy providing \$50 per month for total disability, the loss cost for the added benefit would be \$1.67

¹ LAIRD, *op. cit.*, p. 378.

² See pp. 75-78.

annually. If the increase for hospitalization is only 50 per cent, the loss cost would be 84 cents. Nursing benefits can be added at a cost of 60 cents annually for each dollar per day of nursing indemnity. This method, though crude, produces sufficiently correct rates to warrant its use. The group-hospitalization organizations have found that, on a very large exposure, their members average 0.6 day of hospital confinement per year.

The Statistical Committee of the Health and Accident Underwriters Conference has recommended an annual *pure premium* (provision only for paying losses) of \$5.60 for male risks between the ages of 17 and 49 years for the second type of benefit providing reimbursements for either injury or sickness as follows.

Hospital room.....	\$3 per day, limited to 30 days
Surgical-operation fees.....	Scheduled \$5-\$75
Operating-room fee.....	Up to \$10
Anesthesia fee.....	Up to \$5
X-ray examination.....	Up to \$5
Laboratory fees.....	Up to \$1.50

The hospital-room benefit is estimated at \$2.10; the surgical benefit at \$2; and the miscellaneous items at \$1.50, or a total pure premium of \$5.60. Although the carriers' experience with these rates has not as yet been sufficiently extensive to warrant a positive conclusion, there seems to be every reason to believe that they are adequate. One company has even extended this type of benefit to include reimbursement of physician's fees at not to exceed the rate of \$3 per professional visit while the insured is confined in the hospital. The number of calls is limited to five per week for not more than 10 weeks. A *gross* annual premium (including provision for expenses as well as losses) of \$5 is charged for this feature.

The premiums charged for the unallocated type of accident-expense reimbursement have been set out in a previous table. The Statistical Committee of the Bureau of Personal Accident and Health Underwriters has calculated this premium, and their rates have been generally adopted by the companies offering the coverage. For class A male risks, the premium charged the insured for the base unit of \$500 reimbursement is \$11.75. Additional units of \$100 each may be added to the minimum amount underwritten for a premium of \$1.05 per \$100. The

charge for female risks and the more hazardous occupations is higher, reflecting the greater anticipated claim cost. Because the expense incident to the treatment of the vast majority of injuries will not exceed \$500, the cost of the additional units, like the upper limits in automobile public-liability insurance and other casualty lines, can be written at a smaller proportionate premium than the minimum amounts. The carriers' experience with these premiums for unallocated medical reimbursement has been satisfactory.

Loading.—Up to this point, no attempt has been made to analyze the premium rate into its constituent parts. Insurance premiums are composed of two parts, the pure premium which is calculated to meet the losses and the allocated claim expenses under the policy, and the expense loading which provides for the payment of administrative and agency costs.

The procedure in rate making is to ascertain the pure premium first. The *loading* is then added to the pure premium to determine the gross, or office, rate. The Bureau of Personal Accident and Health Underwriters prescribes for its members the gross premium which the carrier must charge. Individual companies may vary the amount actually expended under the several heads included in the premium analysis, but they may not alter the gross rate. The loading used by the Bureau in its computations is based on the New York State Casualty Experience Exhibit for the years 1924–1930. The following table indicates the

COMPOSITION OF ACCIDENT-AND-HEALTH GROSS PREMIUMS

Item	Accident	Health
Pure premium.....	45.0	50.0
Commissions paid.....	30.8	25.8
Other production expense.....	4.9	4.9
General administration.....	10.0	9.0
Claim expense.....	3.6	4.7
Inspection.....	0.4	0.4
Taxes.....	2.8	2.7
Profit.....	2.5	2.5
	100.0	100.0
Pure premium.....	45.0	50.0
Loading.....	55.0	50.0

relative weights of the factors contained in the gross premium as calculated by the Bureau.

High expenses are characteristic of the disability business. Fifty-two and one-half cents of every accident-premium dollar are expected to be expended on costs other than indemnity; and 47.5 cents of the health-insurance dollar. The multiplicity of small claims, the relatively small size of the premium, and the expense of making sales and renewals because of the competitive nature of the business are factors which affect the amount of expense. The assumptions of the Bureau in making its rates are in the main representative of the practice of the larger stock and stipulated-premium mutual carriers. No provision is made in the loading as given for surplus or contingencies. Rates are kept at a minimum to meet competition. The heavier loss ratio anticipated for health insurance has been noted in the pure-premium and claim-expense factor. The companies have partly discouraged its sale by paying the agent a smaller commission than for accident insurance. Many of the commercial companies have found that the assumptions made in the calculation of the health-insurance gross premiums have not been realized in practice and as a result look with less favor on the coverage.

Not all carriers utilize the Bureau's assumptions. Assessment mutuals operating on the advance-premium plan are required by the laws of some states to make a different disposition of their funds. The usual requirement for such concerns is that the gross premium upon receipt by the association be divided and credited to two separate funds. Seventy-five per cent of the premium or thereabouts is credited to a *claim* or *indemnity fund* to be used in the payment of losses. The remaining 25 per cent is credited to a *general* or *expense fund* from which all the expenses of the business are paid. The association is allowed to transfer from the indemnity to the general fund an amount not in excess of 15 per cent of the premiums received each year. Such transfers are optional with the carrier, and though permitted, the 15 per cent ultimately transferred to the general fund must pass through the indemnity account. For carriers subject to such regulation, the law effectually imposes a limitation on expenses of 40 per cent of the gross premium, 10 per cent less for health insurance and 15 per cent less for accident than is assumed by the stock carriers,

although many carriers operating under such legal requirements are exact counterparts of the stock carriers as far as the general setup of their home-office organization and agency system is concerned.

Since certain of the expenses chargeable to the policy are constant whereas other expenses vary with the amount of the risk, a loading formula using both percentage and constant factors produces the most equitable results. Commissions, premium taxes and certain underwriting expenses are greater with the larger policies, varying directly with the amount of premium. General administrative expenses such as rent, salaries, and travel expense are constant for all policies.

Normally, the variable upon which a carrier's *underwriting results* (premiums received less losses and expenses paid) hinge is the loss ratio—its claim experience—but the expense factor may be equally significant. Unless new business is acquired at a reasonable cost and the general overhead and administrative expenses are restricted to the assumed limits, the company will not prosper in spite of a normal claim ratio. Conversely, savings from loading offer a possible source of profit. Economies in operation are always a focus for the management's attention when claim disbursements begin to mount. Part of a carrier's expenses are subject to some degree of control. Acquisition costs, for instance, are increased by aggressive campaigns for new business which entail outlays for advertising, extra printing and postage, and sales prizes and bonuses. The biggest single item included in the loading, the agent's commission, is not entirely within the control of the management, for individual companies, to be in a favorable competitive position, must meet the standard of the field generally. It has been argued that a commission of 25 per cent or 30 per cent is inordinately large; but such a commission has been defended just as frequently as fair compensation in view of the service which the agent is called upon to render. The question of commissions will be treated in a later chapter, but it should be noted in connection with the loading that much of the underwriters' success in keeping expenses in line with premium income will depend upon their ability to work out a satisfactory solution to the commission problem. Within a certain range, salaries, rents, travel, and furniture and fixture

expenses are controllable items. But the heavy state and Federal taxes, the social-security levies, legal expenses, and allocated underwriting and claim disbursements are largely beyond company regulation.

Most underwriters, if they are frank, will admit that a loading of 50 or 55 per cent even in good times is too large. However, until commissions can be readjusted, the coverage stabilized so as to cut down on the multiplicity of small losses, the increasing tax burden lightened, and state supervision and legislation so standardized that home-office administration can be simplified, the underwriters are powerless to effect any substantial reduction in the expense item.

Group Accident-and-health Rates.—Most group accident-and-health policies do not cover work accidents, and for this reason occupational classification does not play the important part in the rate that it does for most personal forms. The industrial hazard is significant, however, to the extent that the employee's work may predispose him to greater than normal loss due to sickness. The group policy, for an extra premium, can be extended to cover work accidents. Aside from the industry, the group rate depends upon the number of females and unskilled workers covered. Since the morbidity of women and unskilled workers runs higher than that of men and skilled craftsmen, compensating adjustments must be made in the rate if there is a greater than average proportion of them in the group.

There are three methods of scheduling the benefits in the group policy. The *level schedule* provides a flat amount for total disability, usually \$10 per week, for all employees covered by the group policy. A classification schedule may be employed with the amount of the weekly benefit graded according to the type of work performed (*viz.*, clerical, foremen, skilled labor, common labor). Some insureds prefer to have the benefits graded according to the wage scale. A typical wage scale schedule provides:

Amount of Weekly Wage	Amount of Weekly Indemnity
Less than \$15.....	\$8
\$15-\$22.50.....	10
\$22.50-\$30.....	12
Over \$30.....	15

Regardless of the type of benefit provided in the group policy, the premium charge is based upon the total amount of weekly indemnity in force. Most companies writing group insurance have set a minimum of \$5 weekly indemnity per person regardless of the plan but prefer not to write less than \$8 per week regardless of the employee's earnings. In groups of less than 50 persons, the top weekly benefit is usually \$15; but where more than 50 risks are covered by one policy, the maximum is \$40 per week subject to the rule that no risk may be indemnified for more than $66\frac{2}{3}$ per cent of his average weekly earnings. In the smaller groups, the practice is to pay the weekly indemnity for a period not to exceed 13 weeks. With larger groups benefits payable for as long as 52 weeks are written. The first 3 days of any illness are almost always eliminated. Accident benefits may be paid from the first, third, or seventh day of disability.

The total basic cost of the group accident-and-health policy approximates 70 cents per month per \$10 weekly benefit payable for 13 weeks in nonhazardous occupations. Of this total, it is customary for the employer to bear 10 or 20 cents and for the employee to contribute 50 or 60 cents per \$10 weekly benefit.

Group-hospitalization contracts are based upon the same underwriting factors as group accident-and-health policies. Generally, this contract is written only in conjunction with a group-health or life policy and is restricted to groups containing 100 or more persons. Benefits do not exceed \$4 per day for hospital confinement for a period limited to 21 or 70 days in any one year. The unit of benefit is \$1 per day. If the maximum period for which the indemnity is payable is 21 days, the basic rate is 15 cents per month per \$1 unit. For policies providing the 70-day limit, the base rate is \$0.1667 per month. Frequently, the group-hospitalization premium is shared equally by employer and employee.

Accidental-death-and-dismemberment benefits are also written on a group basis. The coverage may extend to all accidents or be restricted to nonoccupational injuries and is usually written in combination with another group coverage. The amount of the benefit will vary from \$500 to \$5,000, depending upon the type of group, number of employees, and total volume of insurance. The rate for the accidental-death-and-dismemberment benefit

covering only nonoccupational accidents is not influenced by type of industry or proportion of women or unskilled workers in the group. If occupational accidents are covered, a classification reflecting the work hazard must be used.

TABLE OF PREMIUMS, GROUP ACCIDENTAL-DEATH-AND-DISEMBLEMENT BENEFITS*
(Per \$1,000 principal sum)

Occupational classification	Annual rate	Monthly rate
A.....	\$1.17	\$0.10
B.....	1.75	0.15
C.....	2.90	0.25
D.....	4.10	0.35
All others.....	5.85 up	0.50 up

* SOPER, L. D., "Study Outline of Accident and Health Insurance," p. 88.

The rates for class A apply if the policy does not cover injuries sustained during the course of or arising out of the insured's occupation. The basic premium rate, once determined for the group, is applied to the number of thousands of dollars of principal sum in force for the entire group to secure the total premium.

The premium determined for the first year is subject to adjustment on any annual renewal date of the group policy. Since the amount of coverage in force will increase or decrease with the number of employees under the plan and with alterations in their wages, the employer is required to maintain an insurance record to which the company has access. Adjustments are made monthly in the premium in accordance with the exact amount of protection which was in force during the month. The insurer may include a provision in its contract which will entitle the employer to a dividend. This *divisible-surplus agreement*, which is usually granted only to the larger groups, is a good basis for securing the cooperation of the employer and encouraging the institution of safety measures and better working conditions among the employees.

There is a general uniformity of practice among group underwriters as to the calculation of basic rates for accident, sickness, hospitalization, surgery, and accidental-death-and-dismemberment benefits. The complexion of the individual group, how-

ever, will usually be such that the basic rate becomes merely advisory. The premium must be weighted for extraordinary industrial hazards and high percentages of females or non-Caucasians. Competition, too, is a not inconsiderable factor in setting the rate which the employer is ultimately called upon to pay.

Special group policies have been developed to meet the needs of particular groups. One of the most widely used is the *volunteer-firemen's* group policy, covering the members of volunteer fire-fighting companies against accident during the time they are engaged in their work as firemen. The premiums are calculated according to the number of pieces of fire-fighting apparatus used and the amount of the benefits, irrespective of the number of firemen in the group. The basic annual rate for one piece of apparatus is \$25 for each \$1,000 principal sum and \$25 for each \$5 of weekly indemnity. A 25 per cent increase in the premium is made for each additional piece of apparatus above the first. The base rate for hospital benefits is \$10 annually for each \$10 of weekly indemnity. Teachers, sports, and students group policies are also becoming exceedingly popular. The flexibility of the group-insurance technique assures its continued growth and future usefulness.

CHAPTER VIII

RESERVES AND REINSURANCE

The maintenance of certain reserves is prescribed by statute in the several states. Not only does the law lay down tests for the adequacy of such reserves, but often the method of calculation is specified. For this reason, company practice as it relates to reserves offers more uniformity than is discernible in any other department of a carrier's activities. Reserves are a test of the carrier's solvency, or its ability to meet the obligations to which it is bound by its contracts. The Miscellaneous Casualty Convention Form of Annual Statement Blank imposes upon the companies the divisions into which they must segregate their various classes of liabilities. The two chief reserves are the *unearned-premium* reserve and the *unpaid-claim* reserve. These make up 95 per cent of the reserve items held by the companies although minor reserves must be set up for *accrued-and-unpaid commissions, claim-adjustment and investigation expense* (frequently lumped with the unpaid-claim reserve), taxes, and bills. Companies often find it advantageous to establish voluntary reserves for contingencies or fluctuations in the value of securities.¹

The Unearned-premium Reserve.—Accident-and-health policies are usually 1-month, 3-month, 6-month, or 1-year term policies. This fact somewhat simplifies the calculation of the unearned-premium reserve. The unearned premium is that portion of the premium which covers the unexpired period of the policy term. It is determined with reference to a single contract by taking that proportion of the total premium which the period the policy has yet to run to date of expiration bears to the full term. This figure can be determined accurately. The reserve is the sum of the premiums unearned on a given date for all the individual policies in force.

¹ MICHELbacher, G. F., "Casualty Insurance Principles," p. 242.

The unearned-premium reserve is based upon the theory that the whole premium is not earned at once, upon its receipt. Rather, the premium is earned gradually over the whole term. The assumption is that the unearned-premium reserve represents the aggregate amount which the company would require in order to return to each insured the unearned portion of his premium were it to cancel all its policies and retire from business. Actually, such a contingency almost never presents itself for the reason that if a carrier is retiring from business it will usually arrange to reinsure its business with another carrier. The reinsurer, taking over the reinsured's liabilities on its outstanding contracts, does so for a consideration assumed to be equal to the amount of the reinsured's unearned-premium reserve, less a commission to reimburse the reinsured for acquisition costs and other expenses already paid.¹ Because of this function which the reserve sometimes performs, it is known also as the *reinsurance reserve*.

In order to arrive at an unearned-premium reserve which would exactly represent the company's liability, it would be necessary to value each policy. At any given time, the unearned premium is that fractional part of the full premium which is obtained by dividing the number of days in the unexpired term by the number of days in the full term. The sum of the unearned premiums for all the policies in force would be the reserve liability. Such a computation would be far too laborious and would take too much time to permit its practical application. Accordingly, the laws sanction a short-cut method. There are two alternative ways of applying the short-cut method. The first way, which is in general use with the smaller concerns, is the *half-yearly* method. The other way is the *semimonthly* method and is favored by the larger companies which, having more adequate statistical and accounting facilities, can easily apply it. The semimonthly method yields more accurate results.

The basic assumption underlying the half-yearly system is that the production of new business is uniform throughout the year; *i.e.*, as many policies are sold in January as in June or December. In theory, then, the average date of issue is July 1. In computing the unearned-premium reserve for the annual statement as of

¹ *Ibid.*, p. 256.

Dec. 31, there would have been 6 months of the premium earned; 6 months would remain to be earned on all 1-year policies written during the year. Figuring on such a basis, 50 per cent of the 1-year premiums written during the year are considered unearned and must be put up as a reserve at the end of the year. This reserve roughly approximates the company's true liability and is easily and quickly calculated. The technique of the half-yearly method can be used by companies which write monthly, quarterly, or semiannual premiums as well as annual business. To secure the unearned-premium reserve on the monthly business, they simply total the year's premium income on all the monthly premium policies and set up one twenty-fourth part thereof as the reserve, *i.e.*, one-half of the average total monthly volume of this type of business. On quarterly-premium business, the reserve is one-eighth of the total volume of these premiums and on semiannual business, one-fourth of the premiums from this source. The state insurance departments permit calculation of the unearned-premium reserve on the basis of 50 per cent of the premiums in force plus 100 per cent of the premiums paid in advance. "Premiums paid in advance" are considered to be those due after the date of valuation and already paid. The formula for determining the amount of premiums in force prescribed by the convention blank is: The premiums in force on Dec. 31 of the previous year plus the premiums written or renewed during the year, less expirations and cancellations during the year. The result is the amount of premiums in force as of Dec. 31 of the current year.

Inasmuch, however, as the assumption that production is evenly distributed throughout the year is not strictly true, certain inaccuracies are introduced into the reserve. New business is seldom spread evenly over the year. Especially with the industrial and quarterly-commercial companies operating in agricultural areas, production rises to its peak in midsummer or early fall and falls off during the winter months when, owing to inclement weather, agents find it is harder to reach prospects and accordingly make fewer sales. Other seasonal, occupational, and geographical factors as well as internal matters such as special sales drives influence production throughout the year. The assumption underlying the half-yearly method tends to create

an insufficient reserve for a rapidly growing company which each year produces more business and penalizes a declining company by requiring of it a redundant reserve.

Because of the errors which creep in under the previously mentioned method, the larger underwriters have adopted the semimonthly method, a refinement which enables them more accurately to arrive at their exact liability. This method requires a monthly calculation of the reserve and is based upon a record of policy years kept by month of issue or month of expiration. It is assumed that within a given month the new business is spread evenly over the whole 30 days. The average date of issue during any month, then, would be the fifteenth day. For policies issued in January, for example, $\frac{1}{24}$ part of the premium would be earned upon the first day of February and $\frac{23}{24}$ would remain unearned; $\frac{3}{24}$ would be earned and $\frac{21}{24}$ unearned by the first day of March; etc. When the unearned-premium reserve is computed, the volume of premiums which the company has received by months is multiplied by the appropriate factor, found as above, the results for the 12 months are summed, and the proper reserve appears. This method, by eliminating any seasonal fluctuations from the assumptions, comes much closer to representing the true aggregate unearned premium. The example on page 187 illustrates the calculation of an unearned-premium reserve by the semimonthly method.

The reserves, it will be recalled, are calculated on the basis of the gross premium. Theoretically, 50 per cent of the premium is posted as a reserve. On a \$100 premium, however, at least \$40 is paid out at once as commission and expenses. This leaves only \$60 for claim and settlement expense. If the claim volume is level throughout the year, \$30 will be needed the first 6 months and \$30 the second 6 months. Actually, the law requires that \$50 be put up for each 6-month period. The statute has called for a gross-premium reserve although the theory of the contract more properly calls for a pure-premium reserve with an added reserve for administrative expense distributed throughout the year.¹ Such a reserve would adequately provide for the rein-

¹ LAIRD, JOHN M., "Noncancellable Accident and Health Insurance Underwriting Problems," *Proceedings of the Casualty Actuarial and Statistical Society*, Vol. VII, p. 301.

insurance functions of the fund. For the present, however, in view of the fact that as yet most companies lack adequate statistics, such a breakdown of the premium would be impractical. The added hidden-surplus factor in the reserve is an extra margin of safety. It is estimated that the companies have an equity of about 40 per cent in the reserves. Statutes are hard to change, and it is doubtful whether any readjustment will be made in the law to bring the requirements more in line with the nature of the companies' obligations. The present laws penalize new or growing companies by requiring them to put up heavier reserves than are actually necessary. This works an especial hardship upon companies issuing noncancelable forms for which the amount of the premiums is larger than for the regular commercial and industrial types. The reserves on noncancelable policies are a special problem which will be treated in Chap. XII.

The Claim Reserve.—The claim reserve is an estimate of the companies' liability upon claims which are not closed. It is composed of the following elements: (1) unpaid drafts, (2) claims on which notice has been received but no proof submitted, (3) long-term claims, (4) regular claims in process of adjustment, (5) contested claims, (6) claims involving death or dismemberment benefits, (7) incurred-but-not-reported claims, (8) adjustment expense.¹

Computation of the reserves for certain of these items is a simple matter. Unpaid drafts are simply totaled and entered at their face amount. Claims for death or dismemberment are put in at the principal sum or greatest portion thereof for which the company would be liable. Contested claims and adjustment expenses are estimated at their probable amount. Such estimation is a matter of judgment based upon experience with previous similar cases and is reasonably accurate.

There are two methods of evaluating the company's liability on regular pending long-term claims. These are the method of *individual estimate* (based upon the company's experience) and the application of an *average value*. The former is in most general use; the latter is used by some of the larger monoline carriers. The method of individual estimate is necessary or desirable (1)

¹ FALLOW, E. S., "Accident Statistics and Reserves," in "Insurance Lectures," pp. 128-135.

CALCULATION OF UNEARNED-PREMIUM RESERVE FOR ANNUAL-PREMIUM
POLICIES AS OF DEC. 31

(1)	(2)	(3)	(4)	Reserve (2) × (3) + (4)
Month written	Amount of premiums written or renewed	Factor	Advance premiums	
January.....	\$5,000.00	$\frac{1}{24}$	0	\$208.33
February.....	5,600.00	$\frac{3}{24}$	0	700.00
March.....	6,000.00	$\frac{5}{24}$	0	1,250.00
April.....	6,300.00	$\frac{7}{24}$	0	1,837.50
May.....	6,100.00	$\frac{9}{24}$	0	2,287.50
June.....	7,200.00	$\frac{11}{24}$	0	3,300.00
July.....	7,700.00	$\frac{13}{24}$	0	4,170.83
August.....	6,800.00	$\frac{15}{24}$	0	4,250.00
September.....	7,100.00	$\frac{17}{24}$	0	5,029.16
October.....	7,500.00	$\frac{19}{24}$	0	5,937.50
November.....	6,400.00	$\frac{21}{24}$	\$50.00	5,650.00
December.....	5,800.00	$\frac{23}{24}$	2,300.00	7,858.33
	\$77,500.00		\$2,350.00	
	Total unearned-premium reserve...			\$42,479.15

NOTE: If the company had written any semiannual premiums, the unearned factors for July business would be $\frac{1}{12}$, for August business $\frac{3}{12}$, etc. For quarterly business, the October factor would be $\frac{1}{6}$, the November factor $\frac{3}{6}$, the December factor $\frac{5}{6}$.

where the amount of the claim is definite, (2) where the number of claims involved is too small to give sufficient spread for the operation of averages, (3) or where the variation in the amount of claims is so great as to prevent the operation of averages.¹

¹ MICHELBACHER, *op. cit.*, p. 242.

Conversely the average-value method is especially suitable where the number of claims outstanding is particularly large and where the claims vary in amount within a comparatively small range, *i.e.*, where the claim dispersion is small.

Individual Estimates.—Carriers using the individual-estimate method usually place an estimate upon the amount of the claim as soon as any information is received which gives an index to its probable duration. The first estimate is placed upon the claim by the branch or field office if the carrier maintains such offices. When the claim reaches the home office, the reserve put up is adjusted as further information is obtained. In computing the amount of the claim reserve, these individual-case totals are gathered together to arrive at the aggregate liability. For death claims, the reserve is the actual amount at risk. Valuation of lifetime indemnity claims is a much more difficult and involved process. The judgment method is inadequate for cases of long duration, and the average method is likewise unsatisfactory, for extended total-disability cases depart so far in duration from the great bulk of other claims. Considerable controversy has been carried on among actuaries and underwriters as to the proper method for valuing lifetime-disability claims. The states have not set up definite standards by statute for commercial accident-and-health carriers, nor have the several insurance departments laid down uniform administrative requirements.

In order to ensure an adequate reserve a number of different factors must be considered. The amount of the company's liability, *i.e.*, the ultimate claim cost, will be affected by the nature of the claimant's disability, his chances of recovery, age, the rate of mortality among such disabled lives, and the interest earned on the reserve posted. To give proper weight to all these factors and to gain the benefit of a wide range of actual experience, most carriers apply *Cammack's Table for Disabled Lives* with interest at $3\frac{1}{2}$ per cent. The companies using this table set up a judgment reserve upon receipt of preliminary notice, adjusting it as the case develops. After 3 to 7 months of disability, depending upon the carrier, the claim is deemed to be one which should be valued according to the table.¹ Even this system, however, will yield satisfactory reserves only when the

¹ SOPER, L. B., "Study Outline of Accident and Health Insurance," p. 52.

volume of claims valued under the table is sufficiently large to secure representative, average results. Without such a volume, the reserve will fluctuate widely from year to year. Because of these difficulties in posting and maintaining reserves which will accurately reflect their liability, many companies prefer not to issue lifetime-disability policies, rather limiting indemnities to a definite number of weeks or months.

Incurred-but-not-reported Claims.—Claims which have been incurred but not reported upon the valuation date must be estimated. The carrier gains a great deal of facility in approximating the outstanding liability from this source by observing its experience over a period of time. In preparing the annual statement, an average of the estimate made for the previous several years, corrected by actual experience, may be used. The figure so determined should be projected according to the current claim trend and variations in the amount of business in force.

Average Values.—The average-value method is simple and economical. The reserve is determined by multiplying the number of outstanding claims by a fixed average value per claim, which is representative of the company's experience with closed claims for the previous year or two years. Some provision must be made in using this method so that cognizance is taken of claim-cost trend. Companies handling a large volume of claims arising from policies whose essential characteristics as to amount of indemnity and extent of coverage are similar can apply the average-value method with highly accurate results. A refinement of this method, applicable where the volume of claims is large, divides the cases by types of contracts and applies an average figure in each class, the reserve being the sum of the class totals.

The average-value method has been criticized as unreliable because it gives no direct weight to the amounts of indemnity or the nature of the disability involved in particular cases. According to one authority, among the principal needs of the business is a reliable table for estimating the incurred cost of temporary disability claims.¹ As long as claim costs are subject to the wide fluctuations which have characterized them in the past few years, the construction of such a table would be extremely difficult.

¹ TARBELL, THOMAS, "Some Observations on Accident and Health Insurance," *Proceedings of the Casualty Actuarial Society*, Vol. XIII, p. 48.

Resisted Claims.—The most conservative practice in connection with resisted claims is to post the full amount in controversy as the reserve. Some carriers follow the not illogical system of posting 50 per cent of the resisted claim, figuring that they have an even chance of winning or losing the controversy. Others attempt to estimate the settlement value of the resisted cases. Some state insurance departments insist upon a reserve equal to the full amount of the resisted claims.

Claim-adjustment Expense.—The reserve for claim-adjustment expense, though an estimate, can be accurately approximated with some experience. Such a reserve figure may be secured by calculating the ratio of the costs of the adjustment work during a period with the volume of claims paid during such period. This ratio is then applied to the claim reserve to secure the adjustment-expense reserve. However, since a large part of the adjustment expense for the pending claims represented in the claim reserve will have already been paid at the date of valuation, such an adjustment-cost estimate is excessive. A modification of this method applies the ratio of paid expenses to paid claims to that part of the claim reserve which reflects the liability for incurred-but-not-reported cases (on which no part of the adjustment cost will have been paid) and a percentage of this ratio to the balance of the reserve. Thus, 5 per cent of the reserve for incurred-but-not-reported claims might be set up to care for the expense of their adjustment, and 4 per cent would be sufficient for the remainder of the claims.¹

Miscellaneous Reserves.—Minor reserves must be computed for unpaid bills, unpaid commissions, and taxes. It is a simple matter to total the outstanding bills. The reserve for unpaid commissions is ascertained by applying the average rate of renewal commission which the company allows to the figure entered in the statement covering premiums in course of collection. In addition a liability item, commissions due and unpaid on premiums already received, must be set up. Because of the multiplicity of taxes which insurance institutions are called upon to pay, the calculation of the tax reserve is not so simple. It will include the state premium tax, income taxes for Federal and state governments, social-security taxes on employees, real-estate

¹ SOPER, *op. cit.*, p. 54.

taxes which have become a lien on the carrier's property, etc. All states levy a tax, usually 2, 2½ or 3 per cent, on the gross premiums of the company derived from business in the state. The aggregate amount due is calculated by applying the tax rate for each state to the amount of business done there during the year. Federal and state income taxes are computed in the manner prescribed by statute and administrative ruling. The social-security-tax liability is likewise at any time a definitely determinable liability. Because of the complex requirements of the various unemployment-insurance and old-age-pension laws and the confusion attendant upon their application, the carriers have to maintain elaborate and expensive detailed social-security accounts. For the larger concerns, these taxes run into amounts of considerable size.

As the disability-insurance business has reached a state of sound maturity, the companies have continuously improved their technique in reserve calculation. The method used in establishing these reserves is extremely important since the adequacy of the reserve is a decisive factor in determining the company's financial condition. If error there must be, it should be on the side of conservatism.

Reinsurance.¹—Because many carriers are called upon to write larger lines of indemnity than they can safely carry upon any single risk, they customarily spread large risks by means of *reinsurance*. Basically, insurance of any kind is possible only where a carrier writes a large volume of similar risks all subject to the same hazard—in short, in a group where the carrier can expect to secure an average experience. When an insurer has issued but a relatively small number of large indemnity contracts, for instance, the exposure may not be broad enough to assure average results. In order to eliminate a widely fluctuating loss ratio, the underwriter shares the risk with a *reinsurer*. Reinsurance companies or *direct-writing* carriers maintaining a reinsurance department can safely accept a part of these large lines for combination with a volume of like risks from other carriers and from the large exposure thus obtained secure an average experience. Although the reinsurance activity carried on in the

¹ For a general discussion of reinsurance see G. F. Michelbacher, "Casualty Insurance Principles," Chap. XVIII.

disability field is not so spectacular as was the case when the companies were writing freely the "jumbo" lines, it is a highly important and little-understood phase of the business. The reinsurer insures the direct-writing company. By enabling companies smaller than the very largest to issue coverage in greater amounts than they could safely carry themselves, the reinsurer makes it possible for the agent to place bigger policies, thus earning larger commissions. By the same token, the policyholder receives better service, having his entire protection under one cover, dealing with one agent, filing but one claim, and paying but one premium. A carrier in a position to place larger contracts through reinsurance facilities can build itself up more rapidly. Although since 1932 most companies have reduced their maximum limits on both accidental-death-and-dismemberment and loss-of-time indemnities, thus relieving somewhat the need for extended reinsurance accommodations, the reinsurer plays an essential daily part in the operation of many disability underwriters.

The need for accident reinsurance was recognized by the underwriters of nearly 50 years ago. By the exchange, or reciprocal, method, increased volume with reasonable spread was obtained. As the business grew, constant demands from applicants and agents of a carrier for higher limits of principal sum and larger monthly indemnities necessitated arrangements with other carriers for writing portions of such risks; and, in turn, reinsurance was provided upon risks of the other companies with which the carrier placed reinsurance. As the business became more complicated with many diverse policy forms and rate structures, the exchange method became impractical.¹

The carriers turned to reinsurance *treaties* (agreements between the direct writer and reinsurer designating the manner in which reinsurance shall be offered and accepted, the limits and rates therefor), arranged chiefly in the London market, as the older methods of handling the problem became impractical. Competition, meanwhile, was forcing the companies to grant increasingly liberal benefits. In the face of increasing hazards which confronted the companies, the profit began to disappear from the business and with it any profit for the reinsurers. Accordingly,

¹ PROPER, FRANK P., "Accident and Health Reinsurance," p. 1.

the London reinsurers began terminating the treaties. Today, there exist only a few such treaties with London groups, and these are largely contingent upon reinsurance of other more desirable lines.¹

In January, 1916, one carrier in Chicago began devoting its entire attention to the reinsurance of accident-and-health risks.² In the same year, 12 Middle-western disability companies arranged to reinsure their surplus business by means of automatic³ treaties. In April, 1925, one treaty was negotiated to cover catastrophic accident losses in excess of \$50,000 and up to a limit of \$1,000,000 upon a group of \$1 newspaper accident policies. The rapid development of reinsurance facilities in this country was spurred by the breakdown of European reinsurance facilities with the beginning of the first World War.⁴ By 1927, casualty companies receiving an annual-premium income in excess of \$9,000,000 were paying 7.9 per cent of their accident premiums and 5.4 per cent of their health premiums for reinsurance.

Reinsurance offers an important competitive and safety device. During the boom days, even small companies were offering contracts providing principal-sum benefits of \$15,000 with double indemnity of \$30,000 and weekly benefits of \$50 to \$100, subject to a 4 weeks' deductible, all for a premium of \$30. No small company could safely underwrite a contract of this kind without the aid of reinsurance.

Reinsurance is a highly specialized and well-developed business which is closely associated with the successful underwriting of every type of insurance. Its technique is highly developed in the marine, fire, and life-insurance fields. In each branch, the characteristics of the reinsurance facilities employed will vary with the problems of the direct underwriter. In general, however, reinsurance is either of the *excess-risk* or the *excess-loss* type. Excess-risk reinsurance attaches only when the amount at risk exceeds the amount which the direct insurer has set as its *retention*, *i.e.*, the amount which it can safely carry itself. The

¹ *Ibid.*, p. 1.

² KOPF, EDWIN W., "Notes on Origin and Development of Reinsurance," *Proceedings of the Casualty Actuarial Society*, Vol. XVI, pp. 68, 69.

³ See p. 194.

⁴ KOPF, *op. cit.*, p. 69.

reinsurer then becomes responsible for its prorata share of any claim large or small which is filed under the coverage. These are the *share agreements*. Excess-loss reinsurance becomes operative only in the event a loss is sustained which exceeds the amount that the reinsured has set as its maximum limit. In other words, under this plan the reinsurer is called upon to share in payment of indemnities only in the event of a large loss and then to pay only the excess of loss above the agreed limit.

Reinsurance is customarily arranged by treaties, or contracts, between the reinsurer and the direct writer. Treaties are of three types: *automatic*, *semiautomatic*, and *facultative*. Under automatic treaties, the direct-writing company may bind the reinsurer to coverage of the risk within the limits and according to the terms of the treaty. The reinsurer has no opportunity to underwrite the risks individually. It simply accepts the direct insurer's judgment of and action on the application. The semiautomatic treaty binds the reinsurer to acceptance of any risk ceded it (assigned to it under the treaty) unless it is already covering the risk up to its own limit of retention. In such a case, the semiautomatic treaty usually binds the reinsurer for 48 hours after the direct-writing company is advised of the situation so that the ceding company can arrange for reinsurance elsewhere. As under the fully automatic contract, the reinsurer does not have the privilege of underwriting the cessions individually. Facultative agreements simply outline the basis upon which a direct-writing company may submit risks to the reinsurer for individual acceptance or rejection.

Reinsurers, when presented with a particularly large or unusual risk, may diminish their risk by retrocession which is simply reinsurance of a part of the risk by the first reinsurer with a second. Through successive retrocessions, extremely heavy lines may be spread over the entire insurance market. Such a practice is more common to marine insurance where, through reinsurance, every carrier may participate in the insurance of the big luxury passenger liners. In disability insurance the jumbo lines have been largely curtailed.

The accepted method of effecting reinsurance in accident-and-health insurance is on the basis of share agreements. Excess-loss agreements have never been popular with the business

because of the inherent inapplicability of this type of reinsurance to the many policy forms which characterize accident-and-health insurance. Reinsurers want to participate in as much of the business as possible in order to get a spread. Excess-loss reinsurance would apply only in the jumbo lines which have been consistently less profitable.

One of the larger carriers has reinsurance facilities which are sufficiently representative to warrant their use for illustration. This company has four share treaties in force. The major agreement, which is automatic, is with a large reinsurance company. On any policy whose benefits exceed the direct underwriter's retention limit of \$30,000 principal sum and \$150 weekly indemnity, the company cedes under its major treaty an amount whose limit is twice the amount retained. Formerly, the company would write contracts whose maximum possible benefits were \$186,000 principal sum and \$750 weekly indemnity. The present maximum is \$30,000—\$150. The other treaties are semiautomatic, for they are with other direct-writing companies as distinguished from purely reinsuring companies. The treaties apply automatically except in such cases as the reinsurer has already granted coverage directly to the risk in question. After exhausting the facilities provided under the major treaty, the company in question cedes an amount equal to its retention under its No. 2 treaty. Under treaties 3 and 4, successively, an amount equal to one-half the retention is ceded to each of two other reinsurers. In all, under the four treaties now in force, the direct underwriter may cede an amount equal to four times its retention. Above that, it must resort to facultative agreements.

Most companies allow the single principal sum or single weekly indemnity to set the retention limit. Whichever policy feature reaches the retention limit first controls the reinsurance. For example, if a company retains \$5,000 principal sum, \$50 weekly indemnity, and \$500 medical reimbursement, on a policy providing \$5,000—\$55—\$500, the weekly indemnity will control the reinsurance and put the treaty into effect. Whatever share is called for under the treaty must be ceded. Some companies, in particular the one whose reinsurance facilities have been detailed, prefer to allow the maximum amount at risk to set the cession to the reinsurer. For example, its retention limit is

\$30,000—\$150. On policies providing no benefits in excess of those amounts, no reinsurance will be ceded. If the policy provides double indemnity, only \$15,000—\$75 will be retained; if triple indemnity is provided, the retention is \$10,000—\$50. In no case, then, can the company's loss on the contract exceed \$30,000—\$150. The reinsurers usually spread the risk further by retrocession. Under the share treaties, premiums, like liabilities, are distributed proportionately. Reinsurers charge a prorata share of the premium after allowing a discount below the gross premium because of the expenses of the direct underwriter in acquiring the business and adjusting the losses.

The policy of reinsurers in negotiating their treaties is to secure as low a retention limit as possible for the reinsured in order that they may participate in as many risks as possible. The passing of triple indemnity and the gradual elimination of double indemnity will allow a reduction in retention limits for carriers such as the one used for illustration. That particular company is planning to allow the reinsurer to participate in all contracts whose benefits run over \$10,000—\$50—\$500.

Taking the reinsurance business as a whole, disability reinsurance does not bulk large. For a time during the depression years 1929—1935, some reinsurers withdrew from the field, but most of them have reentered the business on a more conservative basis, believing in the inherent soundness of the line and hoping to profit from the dearly bought lessons of the past. Most accident-and-health reinsurance is placed with companies which do no direct writing. There are, however, a number of direct-writing companies which maintain reinsurance facilities.

A typical automatic treaty includes among its provisions clauses defining and enumerating the risks covered, the policy forms on which reinsurance will be accepted, the limits of retention and cession, the reinsurance premiums, effective and termination dates, and manner of handling cessions, claims, and taxes and providing for mutual access to records, amendments, and cancellation of the contract.¹ The insuring clause of the treaty simply states that the reinsurer agrees to indemnify the reinsured for a proportionate amount of each loss sustained and paid by the reinsured under the various clauses of the disability-insurance

¹ See sample reinsurance treaty, Appendix V.

policies reinsured. Reinsurance is usually restricted to standard whites, the ages ranging from 16 to 70 for males and 16 to 60 for females. The coverage of the treaty may be further limited by restrictions as to employment and occupational hazard. Sub-standard applicants are handled on a facultative basis. The treaty usually designates by name or form number the different policies issued by the reinsured which are covered by the agreement. The retention of the reinsured and limits to which the reinsurer may be bound are set out. If the retention is low, the reinsurer will ordinarily accept a larger percentage of the risk; but few reinsurers like to assume more than $2\frac{1}{2}$ to 3 times the amount carried by the direct underwriter. On every reinsured case, the ceding company must keep at its own risk its full maximum retention.

Reinsurance premiums are closer to pure premiums than to the rates charged the insured, for the direct underwriter must bear the bulk of the administrative, acquisition, and claim costs even on the reinsured portion of the policy. The reinsurer, of course, must add some loading to the pure premium in order to defray its expenses; but the amount is not large, for it has no commissions to pay and little underwriting or claim costs to defray.

The practice of the several states varies in the incidence of the premium tax on reinsured premiums. Ordinarily, the reinsured pays the tax on all premiums, with the reinsured reimbursing the reinsurer for the tax in those states which levy against it rather than against the direct-writing company.

The reinsurer's liability under an automatic treaty attaches simultaneously with that of the reinsured provided that a reinsurance advice or cession slip is dispatched to the reinsurer within a definite time (usually 5 days) after the issuance of the policy. Some treaties contain the *unintentional-oversight* clause which binds the reinsurer to the risk even though through unintentional oversight the cession slip is not forwarded within the time limit prescribed by the treaty. In such cases, reinsurance advice must be dispatched as soon as the omission is discovered and the premiums from the original due date paid with compound interest at a designated rate. Reinsurers are hesitant to grant the unintentional-oversight privilege, preferring to have liability attach in such omissions from the moment that cession is actually made.

Cessions are made daily under serial numbers on slips which contain the essential data concerning the risks. Under some treaties, the reinsurer has the right to reject or refuse to renew any cession upon 10 days' notice to the reinsured. A monthly *bordereau*, or account current, is rendered by the reinsured to the reinsurer recapitulating all new cessions made during the month and showing all renewals of old cessions as well as all lapses and cancellations of previously ceded business. Settlements are made on the basis of these *bordereaux*.

The reinsured is required to keep the reinsurer advised of any claim in which it may have an interest, giving notice within 10 or 20 days of the date when it receives its first knowledge of the claim and furnishing copies of proofs and other documents bearing upon the adjustment. The reinsured controls the adjustment unless the reinsurer's liability is the greater, in which case the reinsurer may direct the settlement. Any litigation expenses are defrayed jointly on a prorata basis.

Reinsurance is a business depending upon the highest degree of good faith between the parties. The reinsurer has the privilege of inspecting the books and records of the direct writer at all reasonable times. Any information thus obtained must be treated as confidential. Amendments to the treaty are by mutual consent of the parties. The agreement may be terminated by either party in writing to the other upon 1 to 3 months' notice. Nearly all treaties contain a concurrent reinsurance clause which is a proration for other insurance similar to the Standard Provision 17 of the accident-and-health policy.¹

Even the great reinsuring companies have had some extremely bad years, of which 1931 and 1932 were the worst. Six major reinsurance concerns during that biennium received premiums of \$6,183,000 and paid losses of \$6,465,000. Assuming an anticipated loss cost of approximately 60 per cent, the companies referred to sustained losses totaling more than \$2,700,000 exclusive of all expense, for the two-year period. It is no wonder that accident-and-health-reinsurance treaties have been revised or replaced by reinsurers on rather conservative bases.²

¹ See p. 89.

² PROPER, *op. cit.*, p. 2.

It was the costly competition of the direct underwriters expressed in terms of policy frills, inadequate premiums, and loose underwriting which brought both the reinsured and reinsurer to grief when the depression, with its suicides, malingering, and over-insurance, engulfed the business. The losses of the jumbo lines were the most serious. Some reinsurers had written disability insurance purely on an accommodation basis to help secure other casualty lines in which they were more interested. Too little attention was paid to the underwriting standards of the reinsured, and cessions were accepted out of all proportion to the direct underwriters' retention, sometimes running five times the amount retained. To a very great degree, the success of the reinsurer depends upon the success of the direct-writing companies. The steps which nearly all companies took after 1932 in readjusting their underwriting practices and rate schedules have restored accident-and-health insurance to its former sound, profitable basis and have had their reflection in the increasingly satisfactory operations of both reinsurer and reinsured since that time. As the business generally has met its problems successfully the reinsurers' difficulties have been solved.

CHAPTER IX

THE AGENCY ORGANIZATION

An insurance company lives, breathes, and has its existence in the field. Without field representation, the various lines of insurance would not have reached their present stature nor could they continue to expand their sphere of usefulness. To the personal lines, life, health and accident, a good agency organization is especially important, for personal coverage even more than property insurance is sold, not bought. Without a capable, conscientious, producing staff of agents, the skill of the most able corps of underwriters, accountants, investment men—in fact, the whole personnel of the home office—would be of no avail. In the beginning years, any carrier needs a stream of applications in order to get under way and secure an average exposure which will permit the calculations of the actuaries and underwriters to be realized. Even when a carrier has attained some size and becomes a mature organization, the maintenance of its position, let alone the matter of further growth, depends upon the production given it by its agents. Only the commercial “traveling men’s” associations have been able to develop to any extent without field representation. Their successful direct-mail appeal is to a relatively small, rather homogeneous class of risks. The agency problem and the conduct of agency affairs are not a matter which is confined to a single department of the business. Rather, it pervades the whole structure of the company and in its various ramifications affects the great majority of the institution’s transactions. The importance of the selling organization, therefore, cannot be denied.

Function of the Agent.—To the lay public, and in particular in the prospect’s eyes, the agent personifies the institution. It is the unusual prospect or policyholder who has any contact with the institution except through the medium of the fieldman. Few in number are the policyholders who ever have occasion to visit

the home office and meet the administrative personnel of the company. Because of the agent's unique position in the eyes of the public, a company's reputation depends in very large measure upon its agency organization, and that reputation may vary from one community to another in terms of the local agent's ability and attitude toward the business.

The agent exercises a tremendous influence on the company's underwriting by reason of the fact that he originates the business and thus automatically determines its character.¹ Even the most discerning underwriter cannot be held too greatly responsible for bad underwriting results if inferior business is produced for him to pass upon. It is the uniform experience of disability-insurance underwriters and executives that, as the level of the agency organization is raised, loss ratios fall and policyholder relations improve.

The agent is quite as important to the claim department as to the underwriting department. Here again, the initial selection of the business made by the agent will in a large measure determine the kind and multiplicity of the claim adjusters' problems. Proper selling in the first place tends to eliminate the vast majority of all claim misunderstandings. If the business is selected properly in the beginning and the agent explains the protection clearly to the policyholder at the time the policy is delivered, the larger part of the claim department's worries will never materialize.

In still another particular, the agent, his conduct, and attitude toward the business, have a vital bearing on the operation and results of the carrier. It is obvious that a representative who is noncooperative in the matter of collections, remittances, and other financial relations with the carrier or the general agency can be the source of considerable difficulty to the accounting department. Failure to work wholeheartedly with the conservation department, likewise, can spell disaster for the persistency of the business. In fact, there is no branch of a carrier's operations which does not in a very large measure reflect the type of selling organization which represents it in the field. From the attitude of the general public toward accident-and-health insurance as a whole and the carrier which the agent represents in particular,

¹ See pp. 113-114.

down to the most routine detail in the administration of the company, the agent is the axis about which all revolves. It is no more than natural that with the agent occupying such a crucial place in an insurance carrier's scheme of things a tremendous amount of time and attention should be devoted to an analysis of the sales problem and to improving the character of field representation. No phase of insurance has received more adequate treatment at the hands of writers on insurance subjects than selling. The purpose of this chapter, therefore, is not to repeat what has been written elsewhere about the proper development of agents or how to sell; rather, this section will attempt to enumerate the functions of the selling organization and place them in their proper perspective in reference to the other departments of the business.

Historical Development.—Agencywise, the history of disability insurance may be divided roughly into different eras.¹ The first was the era of influence of the claim department. Adjusters looked suspiciously upon claims and approved for payment only those which were forced upon them. Owing to this mistaken and shortsighted attitude, the agents pioneering in this new field were hard put to it to sell the coverage. Because of the noncooperative attitude of the claim departments, some agents became more or less high-pressure artists, ducking into a town, securing what applications they could, and departing as they had come, before any losses had occurred to embarrass them. No business could endure when built upon such shifting sands, and gradually a more enlightened policy prevailed under the leadership of carriers which by the force of their example carried the business into its second epoch, the underwriters' era. The officials at the home office began to pass applications only after the most painstaking examination. Though good underwriting is a desideratum of the business, too conservative a practice stifles growth and by inhibiting production defeats the ends of both the underwriter and the insuring public, preventing a spread of coverage. During this stage of the industry's development, the agent was encouraged to increase his production by the same executives who were admonishing the underwriters to accept

¹ SCHOFIELD, E. J., "Accident and Health Reform Program," *Eastern Underwriter*, May 15, 1931, p. 36.

only the most select risks. Eventually, the agent succeeded in breaking the grip which the underwriter had on the business and literally began to dictate the company's conduct. In response to the demand in the field, the coverage was broadened to meet all sorts of competition. Frills, new clauses, accumulations, double benefits grew almost over night. Once the insurance companies embarked on this competitive spree, there was no stopping. It was like a snowball rolling downhill; for urgently as most wise executives wanted to simplify their policies and standardize their practice, there was little that could be done until cooperative action on the part of a substantial number of carriers could be secured. The decade of the thirties with its disastrous period of depression and recession hastened the crisis. At last the carriers were able to take a more properly balanced point of view, with the result that today, though the agent still occupies a position of importance in their councils, his voice is no longer the paramount factor as it was in times past.

The father of the American accident-and-health agency system is generally believed to have been Major E. V. Preston, who spent his life building the agency force of the Travelers Insurance Company. Major Preston joined the Travelers at the time of its organization and, after serving 2 years as a special agent, was appointed to the newly created office of Superintendent of Agencies.¹ He traveled widely, appointing agents throughout the country and working with them until they grasped the technique of selling accident-and-health insurance. In the early days, it was not an uncommon thing for one *general agent* to have several states under his jurisdiction. For a number of years, the Travelers had one man in charge of the state of New York, another had Pennsylvania and Ohio, and still another the whole Southern group of states. This general-agency system was continued by the Travelers until 1902, when, under the leadership of its new president, S. C. Dunham, that company embarked upon an ambitious program of expansion. The success of the program depended on more and better agents with the result that a *branch-office*² type of organization was set up to give

¹ WAY, JOHN L., "The Agency Organization," in "The Travelers," p. 16.

² For a discussion of the general-agency and branch-office systems, see G. F. Michelbacher, "Casualty Insurance Principles," pp. 393-400.

the home office a more immediate control over the field. The first such branch office was opened at Cincinnati.¹

In the beginning, the agents of practically all carriers had no definite territorial responsibility. Even today, the older general agents still in business can recall that, when they entered the field, the bulk of their work was in personal production, even though they occupied the post of general agent. The remarkable development of accident-and-health insurance since 1900 has left its mark upon the agency organization. Consequent upon the rapid growth of the business, the tendency toward an increasingly urban population, and the rise of weekly-industrial and monthly-premium forms, not to mention the growth of an insurance consciousness on the part of the public with its expectation of a higher type of insurance counsel and service, the duties and responsibilities of the agent have in a constantly greater degree been confined to a successively smaller territory. This evolutionary process has had a stabilizing influence upon the whole business. It has encouraged a closer and friendlier relationship between the agent and his policyholders with consequent better underwriting in the first place, followed by greater persistency and an increase in the agent's earnings as a concomitant result.

The greatest diversity exists as among carriers in the type of agency organization utilized. By and large, monoline accident-and-health insurance carriers still prefer the general-agency system. In multiple-line casualty-insurance companies, the setup of the agency organization will naturally follow the pattern the company employs in handling its many different lines. Ordinarily, the multiple-line casualty company is represented in established general-insurance agencies in the various communities. The larger of these agencies will frequently employ a specialist in accident-and-health insurance who will devote his entire time and talent to the development of this line. The majority of general-insurance agencies, however, have handled their accident-and-health insurance as incidental to their fire and casualty business. The business depression of 1929, which took a toll among the insurance coverages which are dependent upon business enterprise, changed the attitude of many general-insurance men toward disability protection. Since then, many

¹ WAY, *op. cit.*, p. 17.

among them have turned an increasing amount of attention to accident-and-health insurance. They have found that it makes an excellent leader for the general-insurance agency because the personal nature of the coverage encourages an intimate relationship with the policyholder. Having performed a satisfactory service in connection with accident-and-health insurance, the general agency is often able to follow through and secure the other insurance lines which the accident policyholder has for placement. The answer of the general insurance agent to the question, "Why sell accident-and-health insurance?" has been given many times. The logical answer to this logical question embraces the following points:

1. There is a wealth of prospects because everyone whose time is of value should be interested in protecting that most vital asset.

2. Accident insurance is relatively a high-commission line, paying the agent at a rate substantially above other lines.

3. By reason of the high loss frequency which the business develops, the agent has an opportunity to display his insurance "in action" more frequently in disability protection than in any other line. It is estimated that only about 1 fire policy in 1,200 becomes a claim each year, whereas it is generally established that 1 accident policyholder out of 8 suffers some injury during the course of a 12 months' period.

As these and kindred reasons for developing disability business become more apparent and as the business attains an increasingly high degree of stabilization, a greater participation in it by general-insurance agents may reasonably be expected.

Life insurance and accident-and-health insurance are natural bed-fellows. Together they comprise the personal lines and constitute the only complete protection program by which an individual can guard against the hazards which threaten him and his family with the loss of his human-life value. Disability insurance, therefore, finds its most natural outlet through monoline accident-and-health companies and life-insurance companies. From the sales standpoint, monoline companies, of course, are in a position to devote their entire efforts to the promotion of disability insurance. Their agents, for the most part, bend the majority of their efforts to the business. They become experts in

their line. Many of them succeed in thoroughly cultivating their territories and in building up excellent incomes. The life companies share most of the advantages which the monoline companies enjoy. Life, accident, and health insurance have been handled very successfully through the same agency organization. The life and accident salesmen belong to the same species. Knowledge of the personal factors which are important in the evaluation of the risk for life insurance has its direct application in the selection of disability risks. Recognizing the kinship here existing, some life insurance companies start their agents in the accident-and-health department. Their experience has demonstrated that it is easier for the young agent to get on his feet with a minimum of effort by working first with the disability line. He makes a greater number of sales per dozen calls, perhaps because the premium involved is smaller. He can appeal to the selfish instincts of self-preservation which we all have. By thus starting the new agent in accident-and-health insurance, the carriers find that in a considerable degree the necessity of making financial advances to the beginner is reduced, and that the agent so started soon develops sufficient self-confidence and understanding of the profession to take on the life coverage with a higher degree of success than would have been the case had he sold life insurance initially. Among some of the larger groups of affiliated carriers which write all lines of insurance, it has been found advantageous to transfer accident and health out of the casualty company and into the life company. By doing this, the management recognizes the homogeneous nature of the personal lines. For the most part, companies writing life, accident, and health insurance have found that the dual nature of such a service has returned profits in terms of added stability and a wider field of agency effort. The policyholder, too, has benefited by having complete personal protection prepared for him by skilled advisers who could program his entire personal insurance plan with one company.

Industrial accident-and-health companies employ the *debit system* in setting up their field representation: A debit is a premium collection list entrusted to an industrial agent whose responsibility is to maintain and increase the amount of the premiums. His commissions vary with the changes in the debit

total. Because industrial-insurance premiums are payable weekly or monthly, the individual case requires more frequent servicing than is true in commercial or quarterly-commercial business. The debit which is assigned to the industrial agent will include the premium accounts of all the policyholders residing within a prescribed area. In the larger metropolitan centers, some insurers have many hundreds of policies in a few square blocks, and the industrial agent will concentrate his selling effort entirely within that territory. Because of the nature of industrial insurance, the burden of collection falls more heavily on the industrial agent than is the case with any other type of disability insurance. He must make frequent calls in order to keep in force the insurance already on the books, as well as to write sufficient new business to replace that which lapses and to increase the amount of protection which he has outstanding.

Fraternal insurance is sold through a lodge system. In order to operate as a fraternal carrier a society must carry on ritualistic lodge work. Originally all of the insurance written by such a society was placed by the secretary or deputy in charge of the local lodge. More recently, however, because of the increasing professionalization of insurance selling, a number of fraternal organizations have set up agency systems apart from the local lodges proper. These separately commissioned agents work through the local lodges in the solicitation of insurance.

The only type of disability insurance carrier which does not rely upon an agency system deals direct with the policyholder. Commercial traveling men's associations and some commercial stock insurance companies which fall in this class depend upon advertising either by direct mail or over the radio to secure their new business. These concerns are also particularly active in enlisting the cooperation of their membership in the recommendation of prospects to whom they may offer their coverage.

Selecting and Training the Agent.—The greatest single development in the agency field during the last decade was the awakening of a profound interest in a scientific selection and training program for agents. As might have been expected, during the pioneer days of the business and later during its quick adolescent growth from 1900 to 1930, careful preparation for field work was disregarded in the competitive rush for a volume of business.

Though during their infancy the carriers had little which they could teach the agent better to insulate him against the vicissitudes of a selling career in a new field, during the boom years few conceived instruction to be necessary. The average new agent was taken from a shop, factory, office, school, or plow, licensed, given a contract, rate book, and kit of supplies, and turned loose to sink or swim according to his native ability. Under the circumstances, it is not surprising that the annals of most companies are studded with the gravestones of the many who fell by the wayside. Some went down to defeat and turned to other lines because they had little aptitude for insurance selling; others were eventually forced out of the business when the management of the carrier reached an appreciation of the heavy cost of their services in terms of poor underwriting and dissatisfied policyholders.

To the credit of the business of insurance, however, is the marked change in the attitude of nearly all carriers with reference to the selection and training of agents. More and more, insurance selling is being recognized as a truly professional endeavor. This new spirit has been fostered by the carriers individually and collectively through their agency and underwriting associations, by the agents, and by the public itself. The magnificent record of insurance during the business catastrophe of the nineteen thirties has inspired a deeper respect for the institution than was ever previously enjoyed by it. As a concomitant to this high regard is the responsibility of rendering a superior service. In the discharge of this responsibility, the carriers must lean primarily upon their agency organizations.

Life-insurance carriers have led the way to a scientific approach to the selection of agents. Disability-insurance carriers have had the benefit of their researches and have inaugurated efforts of their own along these lines. It has been determined that many factors should be weighed in the selection of an agent. Generally speaking, though granting the impossibility of contracting with the ideal agency prospect in even the majority of cases, it has been found that young men between the ages of 25 and 35, who are married and who have completed at least a high-school education, make the best material. Previous insurance-selling experience is not necessarily desirable—in fact, many agency

some detailed knowledge of the business so that clarity and sales appeal may not be subordinated to technical refinements or submerged in the verbose and sometimes obscure language of ancient legal form.

Policy-form assistance first embraces aid in the preparation of the application, if used as the basis of underwriting. All contracts may be divided into an offer by one party and an acceptance by the other; and the application, when used, is the offer of the applicant to enter into a certain insurance contract, accompanied by more or less detailed statements or representations made as an inducement to the insurer to consummate the contract by acceptance and issuance of the policy desired. In former years, the applicant's statements were made warranties upon the literal and exact truth of which the policy depended. This harsh requirement has been destroyed by both statutory enactment and judicial decision in the field of insurance-contract law, a typical statute providing

No oral or written misrepresentation or warranty made in the negotiation for a contract or policy of insurance by the insured, or in his behalf, shall be deemed material or defeat or avoid the policy or prevent its attaching unless such misrepresentation or warranty deceived the company to its injury.¹

Similar provisions appear frequently in policy-form statutes, a similar requirement being that the policy contain

. . . A provision that all statements made by the insured shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall avoid the policy unless it is contained in a written application, and a copy of such application shall be endorsed upon or attached to the policy when it is issued.²

Hence, the first line of defense against fraud in the procurement of a policy contract is the application. Since a statement therein cannot be a warranty the falsity of which destroys the contract, the application must be carefully designed to elicit information which, if false, "deceived the company to its injury." The blueprints for such a design are the multitude of cases in the courts arising out of false, evasive, or incomplete answers to

¹ Compiled Statutes, State of Nebraska, Sec. 44-322, 1936.

² *Ibid.* Sec. 44-602.

questions in the application. Such cases form the bulk of litigation in the field of insurance of persons. The desirability of insurance is never so vivid as when the possibility of loss moves into the realm of probability, or sometimes of certainty. Within the small space permitted by the usual application form must be written questions which will compel the revelation of all past and present facts material to the risk or which, if answered falsely, will constitute such deception as will vitiate the contract. The objective lies between desirable brevity and compelling adequate disclosure.

In the preparation of those portions of the policy form not standardized by law, the law department should also take part and should bring to the task a comprehensive knowledge of how the agency plant integrates with the home-office agency and accounting departments as well as the legal effect of the instrument to be drafted. Consequently, most companies have become convinced of the desirability of maintaining full-time law staffs whose intimate knowledge of the business develops into a specialized experience which can be built in no other manner. Whether such experience has gone into the preparation of the policy contract or not, the courts assume that expert draftsmanship has been employed in the selection of policy language and have applied with particular exactitude and seeming delight the universal rule of contract law that ambiguity in a written contract must be construed against the party who wrote it. In fact "Judge Ambiguity" has been called upon to decide many insurance cases wherein only an overworked imagination gave him jurisdiction.

Policy conditions, exceptions, and exclusions are the next most fruitful field of litigation, and here, also, the company law staff should give assistance. If the preparation of an insurance contract required a simple statement only as to who or what was insured, the event insured against, and the amount to be paid upon the happening of that event, the task would be easy. But defining the elements of coverage so as to put an infinite number of situations inside or outside the policy coverage is an undertaking the difficulty of which is appreciated only by those who have attempted to do it. In insurance of persons, the precise definition of the insured event is relatively easy where death is the

event, as in life insurance, but clearly defined boundaries are not so readily marked when accidental means plus numerous commonly used exclusions are its basis. Harmony between the insuring clause and the subsequent limitations must pass the careful scrutiny of counsel serving the insured and alert to find a basis of liability encompassing the desires of their clients and the consternation of the policy draftsman. Selecting language to specify coverage for different disabilities and the amount and duration of benefits is likewise a task which the policy drafter must undertake with the certain knowledge that the elasticity of every word he uses will be subjected to test by interested and resourceful legal technicians. Even with the combined skill and diligence of law and underwriting departments, their carefully selected language will sometimes come back in claim contentions, alienated and distorted beyond recognition. Some of these deviously reasoned contentions are occasionally sustained by court decree, and policy draftsmen are sometimes stampeded into endorsing or rewriting the contract to cover every remote contingency without consideration of whether probability of recurrence makes it necessary. Trying to build an absolutely "watertight" contract easily leads into too detailed restrictions and exceptions and may strengthen the erroneous concept that insurance policies are too difficult for the average person to understand and may contain loopholes to avoid payment under a maze of complicated clauses. Simplicity of language and understandable terms are much to be preferred to technical exactitude concerning relatively unimportant phases of the contract.

Claims Work.—At what time in the history of a claim should it be referred to the law department? Some companies follow the practice of reference only when litigation has actually commenced, but the better way seems to be when an attorney for claimant first makes his presence known. Since claim files have ordinarily reached some size before that time, care must be exercised in their compilation. The usual claim jacket, proofs, and routine correspondence are only the bold outlines of a claim, and each home-office or traveling auditor should sketch in the finer shadings with all the information he can gain concerning the claimant's personal and claim history, his attitude toward the present claim and any suggestions of settlement, the persons

influencing him and their position, the reputation and apparent disposition of his physician or surgeon, the ability and standing of his attorney and his probable intentions about the claim, any local history or prevailing prejudice likely to influence the result, and, most important of all, a summary of the claim man's own opinion resulting from the many and frequently elusive impressions that cannot be conveyed to another in writing even by the most detailed effort. These may all add up in the adjuster's mind to the conviction, frequently claimed to be of psychic origin, that the claim ought to be settled.

When the attorney has reviewed such a file, he can then evaluate the situation and in consultation with the claim department determine the course of action. Equal in strength to the court's disposition to resolve ambiguity and uncertainty in the policy against the insurer is the tendency of juries to resolve disputed questions of fact against it. Upon such questions the burden of proof beyond reasonable doubt which is laid upon the prosecution in criminal cases is no heavier than that imposed by juries upon insurers. Sharply disputed questions of fact may as well be conceded, and here it is the duty of the adjuster or investigator to find and incorporate in the claim file the evidence against as well as the evidence in favor of the carrier. Failure to do so has often produced a false sense of security in the attorney's mind, which is later dispelled by a sudden realization in the courtroom that he is far up the river of doubt without essential instruments of navigation. Costly experience shows that only when a suit involves a defense of law or a defense of fact crystalline in its clarity is there practical justification for litigation.

Having decided that such a defense exists, the attorney then determines the mechanics of its handling. He must decide whether the amount or the importance of the question involved calls for participation by home-office counsel. Many companies believe that relatively few cases need more than local counsel. Even in the smaller towns, capable and diligent lawyers may be employed; and, with a well-built claim file before them and guided by the experience and briefs of home-office counsel, they are more likely to attain the desired result than the strange attorney who is regarded as an intruder into local administration of justice.

Agency Contracts.—Agency contracts, the attempted definition of the status of the agent and specification of what the agent may and must do, with commissions as the reward for performance, are another perplexing problem. The danger that detailed provisions for control may erroneously result in the agent being declared an employee, and not an independent contractor, under social-security and workmen's-compensation acts has impelled many insurers to make their agency contracts consist merely of an assignment of territory, a commission schedule, and a provision for terminating the agency. Provisions for direction and control have been largely eliminated with the idea of emphasizing the absence of any employer-employee relationship. Compensation in the form of commissions has been held to be only one indication that the agent is, in fact, an independent contractor. A right to control, though not exercised, has been held indicative of an employee status. Ownership of expirations in the agent and a nonforfeitable renewal have been looked upon as indicia that the agent is conducting an independent business and is not an employee. Multiple representation of companies and the maintaining of an office at the agent's own expense have been said to be strong indications of an independent relationship.

The desire to avoid circumstances giving rise to a decision that the agent is an employee has led to curtailment of drawing accounts and office-expense allowances. Though recent amendments to the Federal Social Security Act have helped dispel the fog, the trimming down of control in agency contracts has forcibly demonstrated that perhaps the detailed agency contracts formerly used were not so desirable after all. If the agent makes representations or promises which his principal, the insurer, is unwilling to assume or cannot or will not perform, a multitude of limitations or specifications in the agency contract will not make the agency function in a satisfactory manner or materially change the responsibility of the insurer to the insured. Although everything which a corporation does must necessarily be done by a human agent, running the gamut from the acts of the president to those of the janitor, the consequences of agency representation in the insurance business surpass in number and extent those which confront other corporations. The power of home-office officials to bind the company or to waive policy conditions or

influencing him and their position, the reputation and apparent disposition of his physician or surgeon, the ability and standing of his attorney and his probable intentions about the claim, any local history or prevailing prejudice likely to influence the result, and, most important of all, a summary of the claim man's own opinion resulting from the many and frequently elusive impressions that cannot be conveyed to another in writing even by the most detailed effort. These may all add up in the adjuster's mind to the conviction, frequently claimed to be of psychic origin, that the claim ought to be settled.

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requirements has seldom been questioned, but many a headache has been caused both insurance officials and judges by questions of the powers of other agents, whether they be called general agents, special agents, local agents, fieldmen, or adjusters.

An agent cannot sell an insurance contract without making statements and representations, unless he resorts to sign language, and even that might be a representation. Telling the agent the limits of his authority is of value as an instructional endeavor; but, unless the limitation be somehow brought home to the insured or applicant, it is of no avail whenever his act is within his apparent authority but in excess of his instructions. The insured is not bound by secret limitations of the agent's authority if the act is within his apparent authority. Provisions in the agency contract aid only when there is a dispute as to the extent of authority between the insurer and agent. Apparent authority is both indefinite and elastic. It may vary with time and geography. It comprehends anything which a reasonable man might deduce from known authority, and known authority is usually only that the agent is duly licensed to represent a particular carrier and that the business of insurance is customarily transacted in a particular way in the community concerned. For instance, the supplying of blank policy forms effective on counter-signature by the agent has been held sufficient to make valid a contract issued by the agent on a class of risk that the insurer had expressly forbidden him to write.

That they may have some protection against unauthorized or prohibited acts of agents, insurers are forced to put limitations in applications or resort to nonwaiver clauses in the policy. In general, these are to the effect that only certain company officials have authority to waive or alter the terms of the written contract or that no agent has authority to vary or alter the contract except by endorsement in writing attached thereto. In many states the courts have held that where an agent has authority to make a contract, he may make a valid waiver of the nonwaiver clause, and the insurer is thus back just where it started from, with apparent authority the basis of the decision. Other states have adopted the more reasonable rule that waiver by the agent when making the contract is binding if within his apparent authority and that knowledge then acquired is imputable to

the company but that the nonwaiver clause is effective after the contract has been issued and delivered. Others enforce the nonwaiver clause as written, especially if it be brought to the insured's attention in an application.

In the field of accident-and-health insurance, the waiver of policy conditions relating to previous health and medical treatment are the most prolific of dispute. Such waiver is always recognized where the agent procures a signature to a blank application and calls upon both his imagination and his knowledge of what is acceptable to fill it in. The next situation arises when the agent, having been given correct answers by the applicant, fills in untrue answers. In nearly all state courts, such action amounts to a waiver, but the Federal courts hold such conduct to be fraudulent collusion between agent and applicant. The next situation involving agents is waiver of delivery-during-health provisions. Delivery with knowledge of existing poor health is usually a waiver unless the insured had notice of the lack of authority in the application. The next frying pan into which it is sought to put the agent is claim of waiver of policy provisions as to time of payment of premium. Outside of cases where the agent is authorized to extend credit, the nonwaiver clause has been held effective to prohibit agency waiver of premium delinquency. Delinquency has been excused sometimes where an agent has authority to collect but fails to appear for that purpose at the usual time after a custom has been well established. The claim of an oral promise at the time of issuance to waive a future breach falls within the protection of a nonwaiver clause. Even courts committed to liberal application of waiver and estoppel refuse to recognize such a contention.

CHAPTER XII

NONCANCELABLE ACCIDENT-AND-HEALTH INSURANCE

From about 1910 to 1930, no phase of the disability-insurance business was more fruitful of discussion and experimentation than *noncancelable* disability coverage. It is the type of contract which vests the option of renewal to a given age solely in the insured and divests the carrier of the right to cancel. Because the noncancelable form in many of its major characteristics is sharply different from the usual commercial and industrial policies, it deserves separate treatment.

Scotland is generally credited with being the birthplace of noncancelable disability insurance. There this type of protection was first offered by the Friendly Societies and the Century Insurance Company of Edinburgh about 1885. The first truly noncancelable policy in this country was issued by the National Masonic Protective Association of Mansfield, Ohio. In January, 1907, it brought out its "whole life health policy," which provided sickness indemnities for total and partial disability without limitation on duration, as well as surgical-operation reimbursement. The contract was noncancelable, guaranteed renewable, and participating and included cash surrender values after the fifteenth year. Rates, graded by age of issue, were calculated on the Harvey Health Table with interest at 3 per cent. Medical examination was required. The National Masonic Protective Association, though its policy forms have been changed considerably from this early prototype, is still a successfully operating carrier and continues to sell noncancelable insurance.

It was not until 1915 that the "non-can" idea gained much of a foothold in the United States when it was adopted by Leonard McNeill, the second president of the Massachusetts Accident Company. The Pacific Mutual Life Insurance Company of California and the Continental Casualty Company were also

among the first to enter this field and contributed much to its development.¹ Within 5 years of its American debut, non-cancelable insurance had gained a wide vogue and was being written by no less than a dozen companies. By that date, the underwriters had successively broadened the scope of the coverage and had removed the principal limitations originally employed. The feeling prevailed among some of the carriers that they had at last achieved a truly perfect form of guaranteed income protection.²

The companies which embraced the noncancelable idea so enthusiastically during those early days thought they saw in it the solution of two problems which had long vexed the underwriter. The sales appeal of a noncancelable contract renewable at the option of the insured appeared to be undeniable, a final answer to the prospect who feared that he might be left without coverage after becoming uninsurable. By building for the insured a vested and continuing interest in the policy, these companies hoped to reduce lapsation. The record of noncancelable insurance during the quarter of a century following its hopeful beginnings is significant not only as establishing the inherent inadequacy of this or any other single type of coverage to answer all the questions of the business but also for the new problems with which it confronted the underwriters. The noncancelable policy did in many respects measure up to its proponent's expectations in dissipating dissatisfaction arising over termination of protection and by reducing lapsation. That these gains were made at a heavy cost to the carriers is a commentary upon the inability of the early "non-can" underwriter, with his lack of adequate statistical information, to foresee the long train of selection, rating, selling, and juridical difficulties which the new form entailed. The only basis upon which the actuary had to work in the beginning was the experience of the English Friendly Societies. The Manchester Unity Table based on the operations of the Odd Fellows Societies during the years 1893-1897 was the most commonly used. Although the experience of these English carriers might reasonably be assumed to have given a clue to the rates of morbidity for which the underwriter should prepare,

¹ KNIGHT, C. K., "Advanced Life Insurance," p. 351.

² KULP, C. A., "Casualty Insurance," p. 583.

actually the conditions affecting insurability and the coverage offered by the American companies varied so widely from those of the foreign carriers that rate making in this country was largely conjectural. The first noncancelable policies in America were issued with a premium rate graded according to age of issue and provided lifetime indemnity for total disability which prevented the insured from engaging in any occupation for wage or profit. Later the companies used a flat rate for all ages but eventually returned to the sounder plan originally employed. This was in part due to the recommendation of the Underwriting Committee of the Bureau of Personal Accident and Health Underwriters which, sensing some of the shoals toward which the companies were steering, reported in 1921 in favor of limiting the coverage to total-disability benefits only, of writing it only with a 14-day (or longer) elimination period, at rates based upon age of issue, and with reserves maintained for both active and disabled lives. That the Bureau's warning was timely is shown by the fact that in the same year its report was rendered, 1921, the premiums charged by the American companies were on the average 50 per cent less than those of the British societies whose coverage was considerably less liberal than the then current forms in this country. In spite of the misgivings of some underwriters, competitive pressure for business relegated the Bureau's recommendations to the limbo of forgotten things.

The high tide for noncancelable insurance was reached about 1925. By that time, a number of the carriers which had originally embraced the idea were beginning to harvest the results of their early experiments. A number withdrew from the field while many of the life companies changed their emphasis to the disability benefit written as a part of the life contract. The high hopes held for noncancelable insurance were being blasted by the necessity for successive rate increases which caused adverse selection and disturbed the agency organization; by the lack of anything approaching adequate statistical information on which the underwriter could chart his course; by faulty selection of risks and the issuance of coverage on a broader basis than warranted by the circumstances because of inexperience in underwriting and selling this insurance; by the continued, progressive liberalization of the contract by the courts and an insurance-

mindful public; and finally, by the uncertainty over what constituted adequate reserves.¹ For the carriers which persisted in the field, the business depression beginning in 1929 was a severe blow, accentuating as it did the earlier errors of overinsurance. Frequently, as the insured's earned income disappeared he developed a disability complex at the expense of the carrier. Loss ratios rose to dizzy heights for all but the carriers which had had the foresight to shorten sail by placing some limits on their liability and by adopting a more conservative underwriting attitude. By the time the worst furies of the depression were spent, all but one company had abandoned noncancelable insurance providing lifetime benefits, and the bulk of the business was written by five companies which offered either the aggregate or the maximum-disability-period types of policy.²

Extent.—Noncancelable disability insurance has been developed chiefly by the stock companies. The mutual companies and assessment associations, quite contrary to their attitude toward early health insurance, have been extremely cautious about entering the field. Their hesitancy may be attributed to the fact that most of them are not comparable in size with the stock companies. The rise of noncancelable coverage was rapid during the middle twenties, jumping from approximately \$4,000,000 in premiums for 1920 to nearly \$14,000,000 in 1926. After that period, the rise was less marked. In 1929 and 1930, the business leveled off with premiums of \$19,275,000 and \$19,836,000, respectively. In 1932, net premiums written totaled \$20,736,000.³ This figure had decreased to \$18,562,825 by 1938.⁴

The table on page 252 contrasts the experience on noncancelable insurance during 1932, a depression year, with 1938 when the business was beginning to recover its equilibrium. Because of the relatively small volume of premiums on this form developed by the mutual companies, their experience, as reflected by the table, cannot be regarded as particularly indicative.

The total accident-and-health premiums received for all lines in 1938 amounted to approximately \$223,000,000, and of this

¹ YOUNG, C. W., "Non-cancellable Accident and Health Insurance," p. 2.

² See pp. 256-257.

³ *Pocket Register of Accident Insurance* (1933), p. 37.

⁴ *Ibid.* (1939), p. 37.

total the noncancelable forms contributed about 8.2 per cent. These figures give no indication of the relative amount of coverage in force, however, for noncancelable premiums are materially higher than those of the other forms.

NONCANCELABLE EXPERIENCE, 1932 AND 1938*

Year	Premiums written	Unearned premiums	Premiums earned	Losses and claim expenses to earned premiums, %	Total underwriting expenses to premiums written, %	Underwriting loss
1932 stock . . .	\$17,020,420	\$6,941,022	\$17,206,000	90.4	34.6	\$4,202,192
1932 mutual . . .	74,446	31,034	77,126	147.1	20.1	55,956
1938 stock . . .	16,642,534	15,085,524†	16,259,012	80.0	35.2	2,578,454
1938 mutual . . .	105,517	227,457	117,020	170.0	31.7	116,556

* "Best's Insurance Reports" (casualty and surety ed.) (1933), p. 730; (1939), p. 757.

† Includes noncancelable claim reserve as well as unearned-premium reserve.

Due to the extremely unfavorable experience of the late twenties and early thirties, many companies withdrew from the noncancelable field. Their position is indicated by the reported average loss ratio of 67.7 per cent for all companies in 1932. Even this figure is calculated on the paid rather than the incurred-loss basis and represents a considerable understatement of the true loss ratio. There is a wide discrepancy between the ratios reported on the two bases as shown in the tables on pages 254 and 255. The seriousness of a loss ratio of over 67 per cent can best be comprehended in the light of the statement by a careful student of the subject, who wrote that the premium charged by most noncancelable carriers made provision for losses of only 35 per cent of the premium during the first policy year and 53.5 per cent thereafter.¹

A list of carriers reporting noncancelable disability premiums for 1938 (page 255) includes many which have long since retired from the field but which still have noncancelable policies on their books. Their high loss ratios reflect the fact that it has been some time since any freshly selected risks were infused into the

¹ KULP, *op. cit.*, p. 587.

group. As the benefit of selection wears off, the tendency of the noncancelable risk is to deteriorate, a fact made particularly apparent as the average age of the insured group grows steadily older. The figures further evidence a past history of inadequate premiums, overinsurance, and improper underwriting.

The Contract.—The noncancelable contract is a combination of the commercial disability policy and the disability benefits of life insurance. The make-up of the contract is essentially the same as that of the commercial policy. The gist of the difference between the commercial and noncancelable policies is in the clause which gives the option of renewal to the insured. A typical clause states: "The insured shall have the right to continuously renew this policy from year to year upon payment of the premium on or before the anniversary date until the insured has attained the age of sixty (60) years."

In order to qualify as a truly noncancelable contract in the public's mind, the policy must be renewable at the insured's option. A few carriers have issued policies which, because of the mere omission of Standard Provision 16 giving the carrier the right to cancel the policy, were labeled "noncancelable" even though the company might refuse renewal at the end of the policy term whether it was 3, 6, or 12 months. This practice led to some little misunderstanding with the result that in most states, through the cooperation of the insurance departments, only contracts which are renewable at the insured's option to at least age 50 may be labeled "noncancelable."

The principal basis for distinction between different types of noncancelable contracts is the presence or absence of a limit upon the company's liability by the contract. The life-income type of noncancelable policy is the older form and the one which has been chiefly responsible for the ills of the business. As the experience on it became successively worse, the form was abandoned by all but one carrier. As the life-income form passed from the scene, the aggregate and maximum-disability-period types of policy have taken its place.

Even though not so much written as formerly, the lifetime indemnity noncancelable contract is important to the student of accident-and-health insurance because of the considerable volume still in force and the lessons to be drawn from the carriers' experi-

NONCANCELABLE ACCIDENT-AND-HEALTH EXPERIENCE, 1932*

Company	Net pre- miums written	Losses paid	Loss ratios, % †
Aetna Casualty.....	\$8,300	\$13,800	166.3
Aetna Life.....	122,700	152,800	124.5
Business Men's Assurance.....	104,100	51,600	49.6
Columbian National Life.....	35,100	21,500	61.1
Connecticut General Life.....	192,000	118,800	61.8
Continental Assurance.....	131,700	42,500	32.3
Continental Casualty.....	1,228,700	609,700	49.6
Continental Life.....	2,100	400	18.8
Craftsman's Insurance.....	110,100	59,700	54.2
Employers' Liability Assurance....	600	500	76.9
Employers Reinsurance.....	2,999,800	1,415,900	47.2
European General Reinsurance.....	2,600	42,800	1624.0
Federal Life.....	316,800	242,700	76.6
First Reinsurance.....	11,600	27,100	232.4
General Reinsurance.....	155,800	335,500	215.4
Great Northern Life.....	9,400	3,800	41.1
Great Western.....	74,500	40,100	53.8
Income Indemnity.....	44,300	45,200	101.9
Life and Casualty.....	383,600	193,400	50.4
Loyal Protective.....	494,900	304,900	61.6
Massachusetts Accident.....	762,500	396,000	48.4
Massachusetts Casualty.....	21,400	5,000	23.4
Massachusetts Indemnity.....	108,800	70,500	64.9
Massachusetts Protective.....	6,884,300	4,947,800	72.3
Metropolitan Life.....	74,400	95,200	127.9
Monarch Life.....	2,201,200	1,341,400	60.9
Pacific Mutual Life.....	3,764,700	3,029,000	80.5
Paul Revere Life.....	304,900	209,500	68.7
Reliance Life.....	39,100	5,500	14.1
Sentinel Life.....	69,500	34,100	49.1
Standard Accident.....	1,700	3,600	207.8
Travelers.....	102,100	193,000	189.0
United Casualty.....	5,900	3,600	61.6
United States Fidelity and Guaranty	6,300	12,200	193.0
Total.....	\$20,736,900	\$14,043,300	67.7

* *Pocket Register of Accident Insurance* (1933), p. 37.

† Loss ratio calculated on the basis of paid losses vs. written premiums.

NONCANCELABLE ACCIDENT-AND-HEALTH EXPERIENCE, 1938*

Company	Net premiums written	Losses paid	Loss ratios, % †
Aetna Casualty.....		\$20,253	
Aetna Life.....	\$88,541	294,310	332.4
Business Men's Assurance.....	72,079	47,547	66.0
Connecticut General Life.....	138,215	177,420	128.4
Continental Assurance.....	84,917	56,776	66.9
Continental Casualty.....	661,277	752,653	113.8
Craftsman's Insurance.....	87,445	44,660	51.1
Employers' Liability Assurance....	604		
Employers Reinsurance.....	61,092	22,763	37.3
Equitable Life Assurance.....	777,080	1,523,308	196.0
European General Reinsurance....	1,825	17,998	986.2
Federal Life.....	181,633	213,885	117.7
First Reinsurance.....	65	25,962	
Life and Casualty.....	200,974	76,962	38.3
Loyal Protective.....	555,541	212,140	38.2
Massachusetts Accident.....	485,129	442,499	91.2
Massachusetts Casualty.....	143,625	61,747	43.0
Massachusetts Indemnity.....	777,263	214,202	27.6
Massachusetts Protective.....	7,079,191	3,861,388	54.5
Metropolitan Life.....	60,433	115,753	191.5
Monarch Life.....	2,625,476	1,211,354	46.1
Mutual Benefit Health and Accident	527,400	180,632	34.2
Pacific Mutual Life.....	2,381,361	2,889,100	121.3
Paul Revere Life.....	1,365,462	694,001	50.8
Provident Life and Accident.....	4,937	465	9.4
Reliance Life.....	125,338	21,450	17.1
Standard Accident.....	281	1,200	427.0
Travelers.....	68,080	239,529	351.8
United Casualty.....	2,792	1,908	68.3
United States Fidelity and Guaranty	4,196	5,632	134.2
Wisconsin National Life.....	703		
Total.....	\$18,562,825	\$13,427,467	72.3

* *Pocket Register of Accident Insurance* (1939), p. 37.

† Loss ratio calculated on the basis of paid losses vs. written premiums.

ence with it. Lifetime-indemnity noncancelable insurance has been written with a number of variations. One type was renewable at the option of the insured to age 60 with benefits paid if the insured was totally disabled from engaging in any

occupation. Premiums were waived after 90 days' total loss of time; partial-disability benefits were limited to 12 months for either accident or sickness, and a 14-, 30-, 60-, or 90-day deductible employed. A somewhat more restricted form, also renewable to age 60, though paying lifetime benefits for total disability from any occupation, provided benefits at 25 per cent the full rate for nonconfining loss of time due to sickness. Monthly indemnities were limited to an amount not to exceed the average earned monthly income of the insured during the 2 years preceding disability. A third form was renewable to age 55 with benefits payable for 52 weeks if the insured was unable to engage in his own occupation and thereafter up to lifetime if he was unable to engage in any occupation. Partial-disability indemnities limited to 6 months were payable at 50 per cent the full monthly rate with all indemnities subject to reduction by one-half after age 60. This form also provided for proration of the claim in the event of other insurance, and monthly indemnities could not exceed the average earnings of the policyholder during the 2 years preceding the loss. A deductible of 30, 60, or 90 days was included.¹

Noncancelable policies as currently issued in any volume fall into two classes: the aggregate type, those placing a collective or aggregate limit on indemnity for all disabilities during the life of the policy, and the maximum-disability-period type, those which limit the insurer's liability for any one disability but which do not impose a collective limit on the total amount of indemnities which will be paid during the life of the contract. The commonest variations of the first type include a form renewable to age 55, paying benefits for 1 year if the insured is totally unable to perform the duties of his occupation and continuously thereafter if unable to engage in any occupation, subject to an aggregate limit of 50 or 100 months. Another variation of this type which is renewable to age 70 provides total-disability benefits for life if the insured, because of injury, cannot engage in any occupation, the other indemnities of the policy being subject to an aggregate limit of 5 years. Partial disability due to accident is indemnified at three-fifths the full rate and is limited to 6 months. House confinement is not a condition to collecting the sickness

¹ YOUNG, *op. cit.*, p. 5.

indemnities. Benefits are reduced 50 per cent at age 60. Still another aggregate type of policy, renewable to age 60, limits all payments for total disability to a period not exceeding 50 months. House confinement is not required, but the form is written only with a 30-, 60-, or 90-day deductible.

Typical of the noncancelable maximum-disability-period contract which limits the company's liability for any single disability without setting an aggregate limit on all the claims which will be paid under the contract is the form which provides total-disability benefits up to 15 months for any one injury or illness. Forty per cent of the full benefit is paid for partial disability, and 50 per cent for nonconfining sickness, each limited to 6 months. Indemnities are reduced when the insured reaches age 60. Recurrence of disability more than 6 months after recovery from the original loss is treated as a new disability provided that the insured had sufficiently recovered during the interim between the two losses to be able to return to his occupation.¹ Other forms variously limit the company's liability for a single total disability from 24 to 100 months. One leading carrier provides 104 weeks' coverage for accident and 65 weeks' for sickness.

It is characteristic of the aggregate and maximum-disability-period forms that they cover a high percentage of all disabilities but recognize a cardinal principle of all lines of insurance—the *stop-loss*—by putting a limit on the company's liability for permanent and recurring losses. It is in this that they differ sharply from the lifetime indemnity forms.

Medical benefits provided under noncancelable forms are not so liberal as the full-medical-reimbursement clauses contained in leading commercial policies. At least one company pays medical expenses for accident, limiting physicians' fees to \$5 per call and two visits per week, hospital expense to \$5 per day for 4 weeks, nurse expense to \$7 a day for a like period, X-ray expense to a sum of \$25, and surgical fees to a limit which varies according to the amount desired by the applicant. The benefits for sickness are restricted to hospital and nurse's expenses. Other companies incorporate the hospital, nurse, and surgical clause used in the commercial form.²

¹ *Ibid.*, p. 6.

² See p. 77.

Waiver of premium is usual in case the insured is totally and presumptively permanently disabled in policies covering disabilities extending over 2 years.

Since the noncancelable forms have been devised with the principal emphasis upon income protection, not all of them provide a benefit for accidental death. Dismemberment benefits, being essentially earnings indemnity, are usually paid monthly. Some noncancelable policies have departed from the basic protection and offer a number of frills in their contracts. The monthly indemnity payable may be doubled in the event that an accident occurs in specified ways. Identification and emergency indemnity is incorporated in the policy. Partial-disability indemnities are scaled from 75 to 25 per cent of the total-disability rate depending upon how much work the insured can do. Surgeons' fees are paid in cases of nondisabling injuries. An accumulation clause providing a 1 per cent increase in the benefits for every month that the policy is maintained in force, prior to claim, and limited to an increase of 50 per cent is provided in one form. Payment of annual premiums rather than quarterly premiums effects a 10 per cent increase in the benefits for another contract.

Most noncancelable policies have an incontestable clause which provides that after the policy has been in force for 2 years, the company cannot deny liability for loss because of any misstatement in the application.

The elimination period is one of the cornerstones of noncancelable insurance underwriting. Some successful noncancelable carriers insist upon at least a 7-day deductible for sickness coverage. Others do a considerable volume of business on a 3- or 5-day elimination form. Although the waiting periods in common use range from 3 days to 6 months, those most commonly employed are for 14, 30, or 60 days. The deductible is not only sound insurance theory but is, in noncancelable insurance, particularly desirable. Insurance should not be used to indemnify anticipated loss—the 2, 5, or 7 days of disability a year which the average individual suffers. Rather, its purpose is to protect against the financial consequences of the protracted, unanticipated illness or injury. The type of prospect for whom noncancelable insurance is intended can carry his own risk for these very short periods of disability without serious personal

financial handicap. To this extent, he coinsures the risk with the company. From the underwriter's standpoint, the deductible, by eliminating liability for the large volume of inconsequential losses, makes possible noncancelable insurance at a premium low enough to be attractive to a wide circle of risks. Even though the single small claim does not involve a large outlay for the company, a multiplicity of them makes the total a very large sum to which should be added a claim-adjustment cost which is naturally disproportionately large in comparison with the amount of the average small claim. Roughly, 60 per cent of all disabilities terminate in 14 days or less, 85 per cent within 30 days, and 90 per cent within 90 days.¹ Claim repeating, the most common cause for cancellation of commercial insurance, is discouraged by the deductible. The prospect who is reckless, careless, or awkward, who "enjoys poor health" or lacks resistance to disease, will prefer coverage which does not carry a waiting period—it makes a better "investment." Although some noncancelable carriers yielding to competitive pressure have reduced the length of the minimum elimination period beyond the point which good underwriting would dictate as desirable and even issue immediate coverage, the deductible is essential if premium rates are to be within the reach of the ordinary prospect.

The miscellaneous provisions of the noncancelable contract vary, but the general tendency has been to cut down on the number of limitations. The usual exclusions provide that no indemnity is payable (1) if the insured is not regularly attended by a physician, (2) for attempts at suicide, sane or insane, (3) for disability resulting from any act of war, riot, or civil commotion, or (4) while the insured is outside the United States or Canada. Some noncancelable forms carry a longer list of exclusions. For the most part, they are similar to those of the regular commercial policy.

Although careful selection in the first instance is the best safeguard against overinsurance complications, some carriers place in their policies clauses to minimize the dangers of other insurance. The contract of one of the leading insurers provides as follows:

¹ SOPER, L. B., "Study Outline of Accident and Health Insurance," p. 74.

If the indemnity provided herein, either alone or together with accident, sickness, or disability benefits payable under all other policies, contracts, or certificates of insurance upon the person of the Insured, exceeds the average monthly earnings of the Insured, for the period of two years (any period Insured was necessarily disabled by accident or sickness not included) immediately preceding the commencement of disability for which the company is liable, the company will pay only such portion of the indemnity provided herein as such average monthly earnings of the insured bear to the combined amount of such benefits payable under all such policies, contracts or certificates of insurance.

In this single clause, the company hopes to minimize the dangers inherent in overinsurance arising either out of the addition of other insurance by the insured or by the reduction of his earnings.

Even so brief a résumé of the provisions common to the non-cancelable policy reveals how widely they differ from the basic elements of the contract which one author summarized a few years ago as: (1) the promise of unlimited monthly indemnity for disability from accident or sickness; (2) coverage of total disability only; (3) noncancelable by the company except for nonpayment of premium; (4) employment of a waiting period of fair length.¹ Partly because of the pressure of competition, partly to interest a public used to the commercial forms, and partly forced by the exigencies of a mounting loss ratio, the carriers have on the one hand elaborated upon the number of different benefits payable and upon the other hand limited the amount of those benefits.

Clyde W. Young, president of Monarch Life Insurance Company, for many years a successful underwriter of the maximum-disability-period type of noncancelable insurance, has summarized the important lessons of a quarter-century experience with the form in the following precepts:²

1. An elimination period, even of only a few days, is of substantial value, particularly as applied to sickness benefits.

2. An adverse experience can be more successfully corrected by a restriction in benefits than by an increase in rates.

¹ KULP, *op. cit.*, p. 585.

² YOUNG, *op. cit.*, p. 8.

3. Full indemnity for nonconfining illness is an expensive feature and one which should be avoided in any noncancelable contract.

4. Contrary to the opinion of the Underwriting Committee of the Bureau of Personal Accident and Health Underwriters, the accidental-death-and-dismemberment benefit has proved to be satisfactory if held within reasonable limits.

5. There is a marked increase in loss ratios as the size of the policy increases, but this may be offset by the decreasing expense rate if too large indemnities are not granted.

6. The agent plays a very great part in determining the loss ratio, a fact which will not change with changing conditions. Because the company cannot correct underwriting mistakes after the noncancelable policy has been issued, the development of a well-trained, cooperative agency organization is an important safeguard.

Rates.—The carriers have been handicapped considerably by the lack of adequate statistics upon which to base their premium and reserve computations. The only experience which was available in the beginning was on cancelable coverage, for the most part limited to 52 weeks' indemnity. The companies looked to England and found that the Manchester Unity experience was the experience most applicable to the situation here, just as the life companies had found when calculating the first rates for their disability clauses. Even so, the English experience was not all that could be desired. The British Friendly Societies provided small indemnities; they dealt with the lower middle class, and in their operation they were pretty tightfisted. The American companies used the English rates of morbidity and loaded them heavily for the variations in American exposure.

The medical examination, which is invariably a feature of non-cancelable underwriting if benefits are to run longer than 2 years, assists the companies in maintaining a low loss rate in the first year. The benefit of medical selection apparently wears off faster from the standpoint of morbidity than of mortality. In the latter case, actuaries figure that medical selection confers a benefit which does not entirely disappear until the fifth year. For the noncancelable forms, however, the low losses during the first year are rapidly supplanted by losses higher than those

sustained under cancelable forms during the later years because the company cannot eliminate the impaired risks which produce the long disabilities.¹ Experience has demonstrated that the peak claim load for noncancelable lifetime-benefit forms occurs between the twelfth and fourteenth years after issue, whereas for the aggregate type carrying 100 months' indemnity the heaviest burden falls between the second and fifth years, thereafter declining until the ultimate level is reached.²

Because the companies had to build from the ground up, there was a great deal of discrepancy in early American noncancelable rates. The following rates used by two of the leading insurers are an example of the diversity of practice in the early days:

RATES FOR NONCANCELABLE DISABILITY POLICIES PROVIDING \$10 PER MONTH FOR THE LENGTH OF THE DISABILITY UP TO AGE 65
(2-week waiting period)

Age of entry	Company A	Company B
20	\$4.17	\$6.00
30	5.26	6.00
40	7.23	6.00
50	11.03	6.00

* CAMMACK, E. E., "Premiums and Reserves for Non-cancellable Accident and Health Policies," *Proceedings of the Casualty Actuarial and Statistical Society*, Vol. VII, p. 268.

The practice of Company B, issuing the policy for a flat premium regardless of age, was more popular. Usually rates were the same from ages 20 to 49 and were increased from 50 to 54, or the benefits were reduced. Experience has shown that the plan pursued by company B will eventually embarrass the company because an insufficient reserve will be accumulated during the early years to meet the later liabilities. What many companies considered as an underwriting profit during their first years in the business turned out to be purely an illusion as the risks began to deteriorate with the passage of time and the carrier could not rid itself of the burden by cancellation.

¹ CAMMACK, E. E., "Premiums and Reserves for Non-cancellable Accident and Health Policies," *Proceedings of the Casualty Actuarial and Statistical Society*, Vol. VII, p. 267.

² "Drop Life Indemnity in Non-can Contract," *National Underwriter*, Apr. 30, 1937, p. 30.

It was pointed out to the carriers at an early date that the flat premium, like the old fraternal life-insurance assessments, overcharged the younger risk and undercharged the older risk. Leading authorities (Laird, Cammack, Craig, *et al.*) advocated the abandonment of such a system and the use of scientific rates based upon age of entry. Since it was manifest that disability under the noncancelable form would increase with the attained age, the carriers were faced with two possible alternatives. Either they could issue the policy on a renewable-term basis, increasing the rate every 1, 2, or 3 years; or they could issue a long-term contract at a level premium sufficient to cover the increasing rate of disability.¹ The first plan is hard to sell and encourages adverse selection in the lapses, and so most of the carriers which abandoned the flat premium turned to the second alternative.

The gross premium each year depends upon four basic factors: (1) rate of disability per year up to age of expiry, (2) rate of mortality, (3) interest rate assumed, (4) loading for expenses, contingencies, and profits.²

As the business developed, the carriers began to accumulate morbidity statistics from their experience. It is surprising, however, that as time went on more adequate data did not develop. Wide variations between carriers in policy forms, underwriting, agency practices, and scope and site of operation have prevented the organization of the available information into a uniform body of statistics. Some companies have compiled their own tables, but a few still rely chiefly upon modifications of the Manchester Unity Tables. The morality factor was ascertainable from life-insurance statistics. Hunter's Table of Mortality among Disabled Lives is established as conservative and applicable to the American hazard.

The Bureau of Personal Accident and Health Underwriters made a considerable contribution to the field when, after studying the coverage, it recommended the following loading factors. The percentages given are in terms of the gross premiums.

¹ LAIRD, JOHN M., "Non-cancellable Accident and Health Insurance Underwriting Problems," *Proceedings of the Casualty Actuarial and Statistical Society*, Vol. VII, p. 301.

² *Ibid.*, p. 303.

NONCANCELABLE LOADING FACTORS*

	First year, %		Renewals, %
Administration.....	15.0	Administration.....	12.5
Taxes.....	3.0	Taxes.....	3.0
Claim settlement.....	2.5	Claim settlement.....	3.5
Medical fees.....	4.5 to 7.0	Contingencies and profits.	10.0
Inspection.....	2.5		
Total.....	27.5 to 30.0	Total.....	29.0

*LAIRD, JOHN M., "Non-Cancellable Accident and Health Insurance Underwriting Problems," *Proceedings of the Casualty Actuarial and Statistical Society*, Vol. VII, p. 306.

No provision for acquisition cost is included in the foregoing. The Bureau made no recommendation relative to commissions due to the diversity in company practice. Commercial accident carriers paid an initial commission of 30 to 35 per cent with nine renewals of $17\frac{1}{2}$ per cent. Life companies, on the other hand, paid an initial commission of 50 per cent and nine renewals of $7\frac{1}{2}$ per cent. Because of the lower aggregate commission, the life companies were able to quote lower gross rates than their competitors.

The following rates were charged for one of the last lifetime noncancelable disability forms issued providing total-disability benefits for the duration of the loss and partial-disability indemnity limited to 12 months. The level premium is graded by age of entry. Only the rate for classes A and B is shown.

NONCANCELABLE DISABILITY POLICIES

(Renewable to age 60.)

Annual premium rates for each \$100 monthly indemnity

Age at issue	14-day deductible	30-day deductible	60-day deductible	90-day deductible
25	\$53.50	\$45.00	\$37.50	\$33.50
30	58.00	49.00	41.00	37.00
35	65.00	55.50	47.00	42.50
40	74.00	63.50	54.50	49.50
45	86.50	75.00	65.00	59.50
50	102.00	90.00	79.00	72.50

These rates represented the best practice in that they attempted to charge each risk with the cost of insurance as

developed for his age group. The inequity between younger and older ages was largely eliminated. The effect of the deductible in providing protection at a lower cost is very evident upon a study of the table.

The following tabulation of rates represents a different practice. They are for preferred risks and apply to one of the maximum-disability-period noncancelable forms. The policy provides indemnity for total disability at the rate of \$100 per month for 15 months, \$40 per month for 6 months of partial disability, and hospital benefits of \$50 per month for 6 months. Benefits are reduced 50 per cent in event of disability beginning after age 59. Rates are flat for ages 21 to 49 and increased 30 per cent for ages 50 to 54.

ANNUAL RATES FOR AGGREGATE NONCANCELABLE COVERAGE

Coverage	Ages 21-49	Ages 50-54
3-day elimination.....	\$28.80	\$37.44
7-day elimination.....	25.20	32.76
14-day elimination.....	21.60	28.08

Another company using the 100-month aggregate form offers a policy which does not require house confinement, pays 50 per cent of full benefits for partial disability limited to 6 months, and carries neither accidental-death nor hospital indemnities. Either a 60- or a 90-day elimination period is used, and medical examination is required. The typical premiums, graded by age of issue from 25 to 50 years, for the \$10,000 aggregate payable \$100 monthly for 100 months are:

Age at issue	30-day elimination	90-day elimination
25	\$56.80	\$46.60
30	62.40	51.30
35	70.30	57.90
40	81.00	67.40
45	96.60	80.80
50	117.70	98.80

The pure premium required for the aggregate type of policy providing a 1- or 2-year limit is 15 to 20 per cent smaller than for the maximum-disability-period type with corresponding limits. This differential decreases as the limit for which benefits will be paid is extended.

Reserves.—The calculation of adequate reserves has been no less a problem than that of adequate premiums. The problems go hand in hand. Frequently during the development of non-cancelable insurance, the carriers have found to their dismay that the old low premiums which they had been charging had not permitted the accumulation of the proper reserve, with the result that they had to dig into surplus to replenish impaired reserves or to pay claims.

A noncancelable carrier may proceed with apparent success even though maintaining an inadequate reserve until its volume of new business begins to level off or decline. Then, with a maturing experience, the company faces the problem of attempting to discharge its obligations out of a premium income and reserve fund grown insufficient because of the increasing rate of morbidity reflected by an aging group of risks.

The purpose of the noncancelable disability-insurance reserve is identical to that of the level-premium reserve in life insurance. Just as in life insurance the rate of mortality increases with age, so in disability insurance the rate of morbidity becomes higher as the insured risks grow older. This factor must be recognized by the commercial accident-and-health-insurance carrier as well as by the noncancelable carrier. However, though acknowledging the trend of morbidity with age, the commercial company can make the convenient assumption of a constant hazard because of certain underwriting safeguards inherent in the commercial coverage which are not available in the noncancelable contract. The commercial policy is a short-term contract, renewable from year to year or quarter to quarter at the option of the parties. If the risk deteriorates too rapidly, renewal may be made contingent upon payment of an adequate premium. Commercial policies ordinarily provide for such an adjustment at age 50 or 55 in the case of sickness protection either by an increase in premium payment or by gradual compensating reduction in the

indemnities provided. Because the noncancelable carrier can neither divest itself of the risk nor alter the rate or any benefit in the contract once issued, it must anticipate the increasing hazard and provide against it.

When faced with an increasing hazard, the actuary may embrace one of two methods, either of which will yield an equally correct rate. On the one hand, the contract may provide for a premium which increases year by year in proportion to the increase in hazard. This is the *natural premium*, the amount collected each year being just sufficient to discharge the claims arising in that year on the business in the group. The natural premium is subject to a number of practical objections, however, which makes its use undesirable. A policy providing an increasing premium is difficult to sell and places the insured in an increasingly difficult position as the years go by, thus encouraging lapses and possibly making it financially impossible for the insured to keep his protection just at the time when his need is greatest. At the same time the poor risks, expecting disability, will make every effort to continue this insurance. For these reasons, noncancelable insurance, like level-premium reserve life insurance, is written on a level premium which is so calculated that over the period of the contract the company will collect from the insured group a sum sufficient to discharge its obligations but with such sum payable by the policyholders in predetermined equal periodic installments. During the early years of the policy, the premium collected is more than sufficient to pay the claims and expenses. Later, as the hazard increases, this premium will not be adequate to discharge the company's obligations. Hence, in the early years it is necessary to conserve and accumulate the excess collected to be drawn upon to meet the later deficit. It is the fundamental theory of an insurance reserve that the company must be able to meet its requirements from its reserve and future premiums to be collected on the business already in force without anticipating profits or income from future new business.¹

That the early noncancelable underwriters underestimated the future effect of the increasing morbidity rate and as a conse-

¹ YOUNG, *op. cit.*, p. 9.

6 Canadian life-insurance companies. The amount of disability indicated by the Class III Table was found to be considerably higher than that shown by either Hunter's or Cammack's Tables. Since the three tables are not set up in the same form, the basic values cannot be compared satisfactorily. One-year term net (pure) premiums derived from the three tables at specimen ages illustrate some of the differences among the three standards. The 1-year term premium represents the cost of the coverage at the attained age shown. These values are given in the following table.

ONE-YEAR TERM PREMIUMS
(Per \$10 monthly income)
Life-income Disability, 3½% Interest

Age	Hunter's total and permanent	Cammack's 3 months eliminated	Class III 3 months eliminated
20	\$0.31	\$0.26	\$1.02
30	0.51	0.60	1.37
40	0.76	1.21	1.92
50	1.41	2.19	3.24
59	3.50	5.31	5.58

Cammack's Table shows a considerably higher cost of disability than Hunter's, except at the lowest ages. Class III is higher than Cammack's at all ages, the relative difference being greatest at the younger ages. The comparison of reserves for active lives according to the three tables is shown in the table on page 271. There is not a great deal of difference between Cammack's and Class III, but costs under both are considerably higher than under Hunter's. In this comparison, it should be pointed out that Hunter's Table relates to "presumably permanent" disabilities. The reserves under Cammack's Table and the Class III Table are not precisely comparable since the former is for a 3-month elimination period and the latter for a 4-month elimination period. This difference in elimination periods would have slight effect on the reserves, however.

In May, 1939, a committee appointed by the Health and Accident Underwriters Conference to construct a table to be used in establishing a uniform reserve basis for noncancelable accident-

and-health policies published the results of its study. To secure as much statistical information as possible, all companies which had written a considerable volume of noncancelable insurance were asked to submit any available data bearing on the problem. Since the Class III Table had been so widely adopted for use in valuing total-and-permanent-disability benefits under life-insurance policies, that table was used as a starting point. The

LIFE-INCOME DISABILITY
(Renewable to age 60)
Terminal Reserves per \$10 Monthly Income

Age	Table	Reserve at end of	
		5 years	10 years
20	Hunter.....	\$2.30	\$4.58
	Cammack*.....	4.17	8.25
	Class III†.....	4.23	8.36
30	Hunter.....	2.79	5.63
	Cammack*.....	4.60	8.59
	Class III†.....	5.00	9.70
40	Hunter.....	3.39	5.90
	Cammack*.....	4.87	8.63
	Class III†.....	5.30	8.44
50	Hunter.....	2.88	0
	Cammack*.....	4.16	0
	Class III†.....	3.06	0

* Three months eliminated.

† Four months eliminated.

Conference Table is primarily an extension of the Class III Table to cover the first 3 months of disablement and disablement commencing between ages 60 and 69, periods which are not covered under the Class III Table. However, in extending the Class III Table to the first day of disability, it was necessary to modify the original figures for the fourth to twelfth months of disability. Thus, the Conference Table and the Class III Table are identical only after the first year of disablement. The committee recommended that the Conference Table be used only as a basis for reserves on active lives and that the net premiums derived from the table be used for reserve purposes only and not for the

computation of gross premiums. It was the opinion of the committee that no active-life reserves other than statutory unearned-premium reserves are required for policies covering accidental injuries only and that the same active-life reserves could be used for policies covering disability due to either sickness or accident as for policies indemnifying for sickness alone. A permissive 1-year preliminary-term valuation method was suggested, as was the use of the American Men Ultimate Table of Mortality with interest not exceeding $3\frac{1}{2}$ per cent for the calculation of the mortality factor.¹

Irrespective of the table used, reserves for different types of noncancelable contracts will vary widely. The heaviest reserves must be posted for the lifetime-indemnity forms which carry no time limit of liability. Each factor incorporated in the contract which reduces exposure eases the reserve requirements. Thus, an aggregate limit, limitation of the indemnity for one claim, age limits for renewals, increases in premiums, or reductions in indemnities all influence the reserve.

In addition to the reserve on active lives, a claim reserve must be set up whenever a loss is incurred just as is the case with the commercial carriers. Some states permit the use of an average method in valuing claims which have run for but a short time. A more scientific yardstick is necessary for reserve computation in the event of prolonged disability, owing perhaps to the tendency of the adjuster to underestimate the length of disability. Cammack's modification of the Manchester Unity Table has been widely used for this purpose. It is graded according to the age of the claimant and the duration of the claim at date of valuation. After age 35, the table departs little from Hunter's Table of Annuities for Disabled Lives and after age 53 is identical with it.² Based upon the old British experience, it is generally conceded that it probably makes inadequate provision for moral hazard in this country. The British results reflect small and decreasing indemnities which of themselves discourage malingering.

¹ For an explanation of these reserve methods, see J. B. Maclean, "Life Insurance," 5th ed., Chaps. VI and VII.

² "Non-can Dangers Long Unperceived," *National Underwriter*, Sept. 25, 1936, p. 19.

The New York Insurance Department ruling of 1926 set up Hunter's Table as the standard for valuing claims of 27 months' or longer duration. For claims of shorter duration, the ruling prescribed the lesser of a reserve based on Hunter's Table or an amount equal to the prospective payments for a period $3\frac{1}{2}$ times as long as the elapsed period of disability, with a minimum reserve of 7 weeks' payments. When the new formulas were set up in 1931, the Class III Disability experience was substituted for Hunter's Table in lifetime-indemnity claims with some modifications permitted for the aggregate forms.

Underwriting.—Selection for the noncancelable forms follows much the same lines as previously indicated for the cancelable coverage. The underwriting must be extremely careful not only from the standpoint of the physical condition of the applicant but also for the moral hazard involved. No form of disability protection offers a better meal ticket to the chronic malingerer than a noncancelable policy. He is free to present as many claims as he wishes, and the company can do nothing about retiring from his risk.

Medical examinations which are uncommon in commercial accident-and-health-insurance underwriting are used widely in the selection of risks for the noncancelable forms. The carriers regularly secure an inspection report on the applicant and take other precautions not felt necessary with cancelable policies. The extent of the pains to which the carriers go in this type of underwriting is indicated by the suggested Bureau loading which provided $4\frac{1}{2}$ to 7 per cent of the initial premium for medical fees and $2\frac{1}{2}$ per cent for inspection purposes.

The ages to which the coverage is extended are somewhat narrower than for the other forms. For the most part, only persons over 21 to 25 years of age and under 55 are eligible. Almost without exception, companies will not write women due to their higher rates of morbidity. Generally the solicitation for noncancelable insurance is confined to persons classified in occupational groups designated A, B, C, or D, but some companies do offer the form to risks engaged in more hazardous work. Any unfavorable physical finding or previous medical history will bar acceptance of the risk. Overinsurance must be carefully watched. Moral hazard, overinsurance, and habits are three

points which the noncancelable-insurance underwriter must scrutinize with extra care in the light of the entire life span of the applicant. Industrial risks who present a picture of low wages and uncertain employment, with possibly unfavorable and unhygienic living conditions and little knowledge of business methods, are to be avoided for noncancelable insurance. A volume of this type of business entails difficulties arising out of inaccuracies in the original application, heavy lapsation, inadequate medical attention when disability occurs, malingering because of unemployment, and claim-adjustment complications. Harder to detect than the industrial hazard is the speculative buyer who may regard his insurance as a retirement annuity or, if engaged in seasonal or uncertain business, as unemployment insurance. The Bureau at one time recommended that no person be granted over \$500 indemnity per month or 60 per cent of his earned income. In view of their later experience, many underwriters would consider this maximum too high, hesitating to issue more than \$200 per month to any risk or participate in a line where all the coverage exceeds \$350 per month. Though such a limit may not approach the insured's earned income, it is large enough to accomplish the function of tiding the policyholder over periods of protracted disability in nearly all cases. It has been suggested that maximum coverage be set by a graded scale which tends to greater equity between risks with big and small incomes.

TABLE FOR GRADING MAXIMUM AMOUNTS OF MONTHLY INSURANCE*

Monthly Indemnity	Maximum Percentage of Earnings
\$100.....	80
200.....	70
300.....	60
400 and over.....	50

* LAIRD, JOHN M., "Non-Cancellable Accident and Health Insurance Underwriting Problems," *Proceedings of the Casualty Actuarial and Statistical Society*, Vol. VII, p. 308.

Brokerage, mail, or volunteer business is particularly suspect in noncancelable insurance. It is increasingly apparent that success in this field depends in a great degree upon the primary selection made by a well-trained, cooperative, and reliable agency organization. The agent in reality determines the quality of the

company's business by the field of his solicitation. If versed in the company's underwriting policy and imbued with its ideals, he can develop a type of clientele which can be underwritten with satisfactory results.

The geographical factor should play an important part in the underwriter's appraisal of the risk. Certain territories are notorious for their antisocial attitude toward insurance companies, because of unfavorable statutes or judicial decisions or an unsound underlying economy which injects a speculative element into the hazard. These areas are well avoided.

General Problems.—The withdrawal of many of the largest carriers from noncancelable insurance has focused attention upon the problems connected with noncancelable underwriting. Many leaders in the business opposed noncancelable insurance from its inception. Some who espoused the coverage in the early days have lived to see their opinion change. Certain it is that noncancelable has not fulfilled the hopes held out for it as a panacea for the ills of the disability-insurance business. Some underwriters believe that the business has gone through its period of adolescence and emerged to come ultimately into its own. A review of the tribulations of the form, the objections filed against it, and the progress made in overcoming them may serve to give perspective on the position of the field today and indicate its possible future development.

Lifetime noncancelable coverage proved to be hard to sell in sufficient volume to get a spread except to the class of persons who had had their commercial policies withdrawn—and these were not the type of risks the companies could underwrite. The agent missed the old frills and talking points which he had used in selling the commercial forms. His prospects wanted the first-day-up coverage and partial-disability and medical indemnities to which they had been accustomed. The graded premium and medical examination were obstacles in the eyes of the prospect which the agent had to overcome. In spite of the greater work involved in placing the coverage, the commission which the agents received was smaller than of old because the renewal commissions were cut. Life-insurance agents were familiar with most of the requirements mentioned above which were new to accident-and-health men, but they had to change

their appeal from the unselfish to selfish motives. In addition to all this, the companies which went into noncancelable insurance were faced with the embarrassing situation of impliedly criticizing their cancelable business, thereby placing it in jeopardy. Many risks which were eligible for cancelable insurance but would not make good noncancelable risks were on the books of the carriers. In bringing out the noncancelable forms, the contracts with many of these desirable cancelable risks were endangered. For this reason, the companies could not push the sale of the new forms so aggressively as they might have done had the situation been different.

From the agency standpoint, it may be said in rebuttal to the foregoing disadvantages cited for noncancelable policies that the graded-scale premium tends to reduce lapsation and makes the closing of sales easier before the prospect's age changes. In the long run, the noncancelable companies claimed that their agents would be better off because of the possibility of building up a permanent clientele comparable with that of the life-insurance agents, which would yield a comfortable renewal income.

The lifetime-indemnity noncancelable policies proved to be hard to underwrite on a long-time profitable basis. Agents had been trained to a short-time viewpoint, and under the cancelable contracts the company could partly correct errors in underwriting which slipped through. Under the noncancelable policy, no such device was open to the underwriter.

Life insurance is universally regarded as a necessity. The tendency to adverse selection is reduced to a minimum. On the other hand, in accident-and-health insurance, there is a tendency for the poorer risks to insure and to continue their protection. This tendency to self-selection is apparent even in the choice of waiting periods. The asthma sufferer will seek a policy carrying a 2-week deductible because his attacks are frequent and of short duration, whereas the person who is afflicted, or has reason to believe he will be afflicted, with tuberculosis will spread his premium dollar further by selecting a 3-month elimination period.¹ Even the person who has abstained from filing trivial claims under his cancelable contract will enter such claims under his noncancelable policy because he no longer is subject to the

¹ LAIRD, *op. cit.*, p. 309.

fear of cancelation. Recognizing the great moral hazard which presents itself under the noncancelable form, the underwriters refused to incorporate any surrender values in the contract because, by permitting surrender for cash value, the tendency to adverse selection would be increased.

One of the chief difficulties experienced in administering non-cancelable insurance was found to be the difficulty of building the required reserves in the face of the volume of small claims presented by the claim repeaters. Because the loss from this source even in the early years so far exceeded what was anticipated, it was impossible to conserve a part of the premium as had been contemplated in order to meet the expected heavy losses at the older ages. The carriers have found that disease may prevent older men from returning to the only occupation with which they are familiar; and so, even though they do not continue to be permanently and totally disabled, they turn into regular pensioners. The depression contributed to this situation.

A technical difficulty arises out of the very nature of the noncancelable reserve for, like term life insurance, although the reserve under the policy increases for most of the period the contract is in force, at a point a few years before expiry the reserve begins to decrease until at termination the reserve is exhausted. This is significant because it means that the net amount which the company has at risk is greater during the final years of the policy, or precisely at the time when, owing to age, the hazard is the greatest. To the life companies, this phenomenon is of little consequence because of the precise predictability of the life hazard; and, with the bulk of their business, the ordinary life and endowment policies, the reserve grows each year, thus constantly reducing the net amount at risk. Noncancelable disability companies, however, have suffered from this situation as their risks approached the age of 60 years. A claim at the older years is also more costly to the company because the probability of quick recovery is smaller. Life insurance has had the advantage of well-trained agents and underwriters, a conservative table for rates and reserves, and good statistics on substandard lives. Because noncancelable disability insurance enjoyed none of these advantages, its experience has been full of trials.

The mere fact that the experience with lifetime-indemnity noncancelable insurance has almost uniformly been trying, difficult, and unprofitable does not necessarily condemn noncancelable insurance. Few would argue with the objectives of the noncancelable policy or deny the existence of a definite field for this type of protection. In the development of the aggregate and maximum-disability-period forms, due recognition being given to the time-tested principles of sound underwriting common to all kinds of personal insurance, a number of carriers have demonstrated that noncancelable insurance can be written with benefit to the insured and profit to the company. They appreciate that noncancelable insurance is not the answer to all the problems of the business but rather occupies a definite, if somewhat restricted, place in the field of accident-and-health insurance. In the hands of skilled underwriters and agents insuring carefully selected business and professional risks for moderate amounts subject to well-defined limits, there seems to be no sound reason to doubt the continued growth and prosperity of carriers offering noncancelable insurance.

Many casual observers of the business have confused the ills arising from lifetime benefits with the underwriting problems incident upon the renewable nature of the coverage. In point of fact, the lifetime benefits, particularly for sickness, have been responsible for more difficulty than the inability of the company to retire from the risk, as is brought out by the comparison of loss experience for aggregate and lifetime-benefit companies in years of both prosperity and adversity as shown in the table on page 279.

By recognizing the necessity for a stop-loss in disability insurance as in practically all other lines, the underwriter automatically simplifies his reserve problems without impairing the value of his protection appreciably to the average honest insured.

Some advocates of the lifetime-indemnity form argue that it could be successfully underwritten either on an assessment basis or with a redundant premium, any excess above the amount needed for claims and expenses to be returned to the policyholder in the form of a dividend. Critics of this proposal point out that, even given the right to do so, carriers are loath to call for an assessment above the stipulated rate because of the adverse

COMPARISON OF LOSS RATIOS*

Year	Aggregate companies, %	Lifetime companies, %
1925.....	66	96
1926.....	62	76
1927.....	67	72
1928.....	64	76
1929.....	57	73
Average 1925-1929.....	63	77
1930.....	61	79
1931.....	65	92
1932.....	69	111
1933.....	68	162
Average 1930-1933.....	66	111

* YOUNG, C. W., "Non-Cancellable Accident and Health Insurance," p. 8.

effect upon the persistency of the business. The uncertain nature of the liability incurred under a lifetime-disability cover makes it difficult if not impossible to calculate the size of the assessment required on the one hand or the amount of the dividend which might be returned on the other. The redundant premium is objectionable because of the sales resistance which it would engender. The prevailing sentiment among the majority of the students of the business was expressed by John M. Powell, president of the Loyal Life Insurance Company, who in pointing out that less than one-half of 1 per cent of all disabilities extend beyond 1 year in duration, said:

It does appear that the practical answer to this social problem is to grant coverage on the basis of a maximum liability and as reliable experience accumulates to extend that period rather than to promise something the cost of which it is impossible to know at the present time.¹

With the practical elimination of noncancelable insurance on a lifetime-indemnity basis, some commercial underwriters have contended that the effect of the noncancelable feature is practically nullified since the insurance is automatically canceled when the aggregate limit has been paid. It is true of some

¹ CALKINS, RICHARD A., "Some Observations on Non-Can Forms," *National Underwriter*, Oct. 9, 1936, p. 2.

aggregate forms carrying a 12- or 15-month collective limit that they do fall short of the goal of guaranteed protection; for each time the insured receives indemnity the amount he may collect in the future is reduced accordingly, and since there is no provision for returning the premium there is in effect an automatic increase in the rate.¹

Regardless of the imperfections which admittedly exist, non-cancelable insurance has made and promises to continue to make in its newer forms a definite contribution to the evolution of the service which disability insurance performs. In its present state, it offers an attractive type of protection to the select risk.

The history of this line of insurance is not a pleasant story. It is a story of bright hopes followed by bitter disappointments. However, few new developments have ever been successfully established without a period of experience so adverse as to be almost disastrous. The experimental work is not over, but so much has been learned that I feel we are out of the woods and on a road where the more dangerous corners, at least, are marked.²

¹ SOPER, *op. cit.*, p. 75.

² YOUNG, *op. cit.*, p. 10.

CHAPTER XIII

HOSPITALIZATION INSURANCE

Perhaps the most profound of all the manifold and persisting effects of the business cataclysm which seized the United States in 1929 was the change wrought in the economic philosophy of great masses of the people. Insidiously, probably without any consciousness upon the part of the public, ideas of "collective security" were propagated and gained wide acceptance. Judged by their expression through politically elected representatives and organized labor movements, millions of people declared themselves willing to discard the traditional laissez-faire doctrine and its concomitant opportunity to "make a million or starve to death," in order to embrace a managed economy promising "security" if not opportunity. This movement took concrete form in the Social Security Act of the Federal government and coordinate acts of state governments providing compulsory social-insurance benefits for the aged and unemployed. To this change in the mass social and economic thinking, more than any other one thing, may be attributed the phenomenal acceptance and growth of hospitalization insurance.

Although hospital benefits had been a part of the protection offered by accident-and-health-insurance companies for many years, it was not until after 1929 that there was any popular large-scale demand for this type of indemnity. The lack of interest before that date may constitute a criticism of the business for failing to recognize a real field of service through the reimbursement forms and to stimulate a market for it among the insurance-buying public. Indemnification against the costs of disability—not alone the wage loss, but the direct expenses incurred for hospital and medical care as well—is an insurance problem. It is axiomatic that disability and its attendant expense cannot be accurately predicted for a given individual. Hospitalization insurance, however, like all insurance coverages,

operates on the premise that the loss from this source can be predicted for a group large enough to permit an average experience and the cost so determined apportioned among the members of the group. The hospitalization plan substitutes a small certain loss, the premium, for the risk of a large uncertain loss, the expense of hospital treatment. Irrespective of the method of reimbursement employed, whether by a cash payment to the insured or by actually rendering the hospital services themselves, the company or association which serves as the risk bearer is actually performing an insurance function.

Voluntary, Nonprofit Hospital Associations.—Group-hospitalization plans seem to have evolved from two sources, the early contract-practice plans which made medical and hospital services available to remote mining and lumber communities on a payroll-deduction basis, and the mutual-benefit plans organized by fraternal societies and labor unions as a substitute for "passing the hat."

The Baylor University Hospital at Dallas, Tex., is generally recognized as having introduced the first group-hospitalization plan.¹ In December, 1929, this institution agreed to provide hospital privileges to a group of 1,500 Dallas school teachers who were members of a local benefit society. At a cost of \$6 per year per member, the Baylor plan included hospitalization in semi-private accommodations with no extra charge for the use of operating room, laboratory service, or drugs and dressings.² The plan attracted some little attention and was initiated at other institutions throughout the Southwest. It was not until after 1931, however, that the hospitalization movement began to assume anything like its later proportions. By that time, hospitals everywhere were beginning to feel the pinch of the depression. Hospital income from endowments and voluntary contributions decreased by two-thirds while the charity load increased fourfold. In many cases, with huge capital investments to service and other fixed costs remaining unmet, the hospitals found themselves in desperate financial straits. It

¹ ROREM, C. RUFUS, "Hospital Care Insurance," p. 3.

² REEDER, J. D., "Hospital Insurance, Its Past, Present, Future," *Mutual Underwriter*, July 25, 1939, p. 5.

was not surprising, therefore, that hospital managers grasped at the group plan as a means of bolstering hospital revenues.¹

By 1932, the "city-wide, free-choice" plan began to supplant the single-hospital type of plan. Under the newer arrangement, all or a majority of the recognized hospitals of a city would join together in a single association agreeing to furnish hospital services to the members of the insured group for a predetermined scale of fees to be paid the participating hospitals by the association. Each insured was allowed free choice as to which participating hospital he would elect to use. The advantages of this type of plan were the elimination of competitive proposals by different hospitals within the same city and a greater latitude for the insured patient in the selection of facilities. The general principles of group hospitalization were approved by the American Hospital Association in 1933, and an advisory and consulting service was established for all plans approved by it. In 1934, the American College of Surgeons set up certain prerequisites for its endorsement. These criteria called for emphasis upon public welfare, nonprofit sponsorship and control, the enlistment of professional and public interests, free choice of hospital and physician, economic and actuarial soundness, limitation of function to rendering hospital services only, and dignified promotion and administration.

Coming to the forefront of public attention during a period of great economic insecurity, the hospitalization plans enjoyed a phenomenal growth. From one free-choice plan enrolling some 2,000 members on Jan. 1, 1933, the movement had expanded to 33 city-wide associations with 968,000 members by July 1, 1937. On that date, there were at least an equal number of single-hospital plans in operation. The succeeding 2 years witnessed an even greater spread of the movement. It was estimated that some 4,500,000 persons were entitled to the privileges of membership by Jan. 1, 1940, through some 60 plans. One group alone, the Associated Hospital Service of New York, with some 300 participating hospitals, had in force more than 395,000 subscribers' certificates covering 1,358,000 persons.²

¹ "Group Hospitalization," p. 7.

² ROREM, C. RUFUS, "Non-Profit Hospital Service Plans," pp. 7-9.

It should not be inferred from this rapid growth that the development of group-hospitalization plans has been without its attendant problems. Even the legal foundations upon which the plans were erected were not altogether sure. The organizations behind these plans being most frequently chartered as nonprofit corporations, in the absence of specific enabling statutes the plans were open to legal attack either as insurance carriers which had failed to incorporate and operate under the insurance code or as corporations engaging in the practice of medicine contrary to law. Much of the justified criticism of the group-hospitalization associations arose from the fact that in many states they carried on their insurance function under the guise of a nonprofit, charitable institution free of insurance-department supervision and exempt from most state taxes. Each jurisdiction applied its own interpretation of the nature of the groups, with great resultant confusion. Gradually, however, special enabling acts were passed by the various state legislatures making special provision for the incorporation of nonprofit group-hospitalization associations. New York led the way in 1934 by amending its insurance statute to make special provision for the incorporation of nonprofit hospital associations. This enabling act was broadened to include nonprofit medical-indemnity corporations when the 1939 legislature adopted a new codification of the insurance law. By 1939, 24 states, having a population of 88,000,000 persons, had laws on the books placing these groups under the direct supervision of the insurance department or the departments of health or welfare. Another 9 states, with some 21,000,000 population, permitted the formation of such plans under general corporation laws on the assumption that the plans are not "insurance." The other 15 states presumably permit hospitalization insurance to be supplied only through stock and mutual insurance companies or associations.¹

Although each nonprofit hospitalization association has its individual characteristics, all adhere fundamentally to the same general plan. Hence, the description of one representative organization will serve to picture all. The largest and best known association in 1939 was that serving the metropolitan area

¹ American Hospital Association, *Hospital Service Bulletin*, Oct. 1, 1939, p. 5.

of New York. The Associated Hospital Service of New York was organized and commenced business in May, 1935, pursuant to the amendment of the New York insurance law passed the preceding year, permitting the incorporation of such groups. In common with most group plans which are initially financed by contributions from the local hospitals, philanthropists, or civic groups, the Associated Hospital Service began with grants of \$25,000 from the Commonwealth Fund and \$5,000 from the Josiah Macy, Jr., Foundation. Initially, 93 hospitals agreed to cooperate in the plan. Later the number grew to over 300, located in the vicinity of New York. These hospitals, under contract to the Associated Hospital Service which acts as a middleman between them and its subscribers, agree to render the hospital services defined in the plan's certificate of membership for a predetermined schedule of fees. Payment is made directly to the hospital by the Associated Hospital Service whenever a member is a patient at one of the participating institutions. From the subscriber's point of view the group plans differ materially from accident-and-health insurance in that the benefits of the contract are payable in terms of service rather than cash indemnity.

The Associated Hospital Service has secured its subscribers through salaried representatives who make the necessary arrangements for the enrollment of groups ranging in number from 5 to 5,000 persons. Individuals as such have not been accepted although individual applicants were permitted to subscribe in groups of 5 or more. This practice was discontinued because of self-selection, the New York association canceling some 57,000 individual subscribers on Sept. 1, 1939. The associations have learned the wisdom of following insurance-company technique requiring that the group insured must have a common employer or have been formed for purposes other than that of obtaining insurance.¹ Three types of membership are available through group enrollment: individual, husband and wife, and family. The premium charged depends upon the type of membership and manner of payment, *i.e.*, whether direct or by payroll deduction through an organized group. The schedule in force as of October, 1939, called for annual charges of \$9.60 for the individual, \$19.20 for husband and wife, and \$24.00

¹ *Mutual Underwriter*, Oct. 25, 1939, p. 9.

for a family, under the pay-roll-deduction plan. Corresponding rates for organized groups operating through a "remitting agent" or group secretary (not under pay-roll deduction) are \$10, \$20, and \$24. In most of the organized groups the premiums are paid on a monthly basis.

The certificate of membership entitles the subscriber and his family group to "necessary" hospital services, recommended by a physician, including semiprivate room-and-board service for 21 days each year on one or more admissions. This service includes general-nursing service. Provision is made for use of an operating room up to a charge of \$25; X ray up to \$25: anesthesia when administered by a hospital employee; and laboratory examinations for diagnostic purposes up to \$20. Family contracts of the organized-group type provide maternity benefits covering expenses up to \$5 per day, limited to 10 days, after the mother has been enrolled for 11 months or more. If the subscriber is forced to remain in the hospital for a period longer than the allowed 21 days, the contract secures for him a 25 per cent reduction in his hospital bill, if using semiprivate accommodations, for an additional period of not to exceed 60 days. If the subscriber elects to use private accommodations rather than the semiprivate facilities provided by his certificate, the association will apply the amount of the daily rate which would be otherwise payable to the hospital under its contract against the charge for the accommodations used. The contract does not provide services for mental sickness, pulmonary tuberculosis, or venereal or quarantinable diseases. No coverage is extended to cases for which workmen's-compensation benefits are payable or to X-ray and laboratory examinations for purely diagnostic purposes. The association assumes no liability to pay for any service rendered by the subscriber's physician, surgeon, or private nurse or any ministration of any clinic, dispensary, or out-patient department of the hospital. A waiting period of 6 months is provided before the contract covers tonsil and adenoid cases which are restricted to 24 hours' coverage for infants and 40 hours' for adults. In the event of emergency cases outside the metropolitan area, the plan allows some cash benefit to the subscriber.

While more liberal than some of the smaller plans, the Associated Hospital Service of New York presents a fairly representa-

tive pattern of nearly all nonprofit hospitalization groups. The rates charged by most groups for an individual risk approximate 75 cents per month with a few as low as 60 cents and some as high as \$1. The combination rate for husband and wife is usually slightly less than double the charge for either husband or wife singly. Two dollars is the usual monthly rate for both parents and all dependent minor children, 1 to 19 years of age. New risks are accepted variously from age 1 to 65 or 70, and usually there is no age expiration limit. There is a high degree of uniformity as to the type and amount of hospital service provided the subscriber. Medical, surgical, and nurses' benefits are not usual under these contracts. Aside from tonsilectomies, the most common disabilities affected by a waiting period are appendectomies and herniotomies.¹

In their earlier days, the hospital plans attempted little in the way of underwriting their risks. However, even a rapidly expanding membership could not dim the fact that "the financial soundness of the nonprofit hospital plans depends basically upon the selection of the risks," as one group director has said.² Gradually, the plans have developed certain underwriting criteria around the method of enrollment used. When subscribers are secured through the place of employment on a group-remittance basis, the better practice requires subscriptions from at least 10 employees. To lessen selection against the plan, the maintenance of a minimum-percentage enrollment is desirable. Applications should be submitted sufficiently prior to the effective date of the coverage to secure payment before that time. Supplementary enrollment should be permitted only on the anniversary date of the cover, or on regular semiannual dates in large groups. No applicants over age 65 should be considered, and coverage should be in strict accordance with the marital status of the prospective subscriber. In other words, all subscribers who are eligible for the combination or family coverage should be required to take it. Collateral dependents such as brothers, sisters, grandparents, etc., have proved to be expensive risks who

¹ *Report of the Special Committee on Hospital Insurance of the Health and Accident Underwriters Conference* (1939), p. 4.

² DURGOM, J. ALBERT, "Hospitalization Enrollment Procedure," *Best's Insurance News* (fire and casualty ed.), September, 1939, pp. 19 f.



cannot be handled satisfactorily under the usual plan. If the enrolled group is composed of more than 50 per cent females, the higher anticipated morbidity can be offset partly by setting a higher minimum-enrollment requirement.

Where group enrollment is accomplished through the place of employment or a professional association but on a personal, direct-payment basis, the underwriting standards suggested for the group-remittance type of enrollment should be maintained with some modifications. Because of the likelihood of a less homogeneous group and to offset higher lapsation, the group should consist of not less than 25 members with a 10 per cent higher minimum-enrollment requirement. Some associations have permitted membership on an individual basis where a person could not qualify through an eligible group. Experience has demonstrated, however, that this type of membership is quite undesirable from the standpoint of the organization. About three times as many women as men apply as individuals. Young married couples selecting against the maternity benefit have proved to be expensive risks. As a result, most associations have severely restricted the availability of individual memberships or withdrawn them altogether.¹

The initial failure of most associations to establish conservative underwriting practices led to difficulties such as the New York and Boston plans experienced in 1939. Enthusiastic over its rapid growth and permitting the social significance of the work to overshadow the conservative insurance aspect, the New York group early in 1938 liberalized its benefits by extending the period of hospital care from 21 to 30 days and by making similar adjustments in other phases of its coverage. In less than a year, the experience under the revised form had become so unfavorable that the association was forced to make application to the New York State Department of Welfare for approval of a reduction in basic rate of pay to the hospital for bed, board, and hospital service from \$6.75 to \$5.06 daily, a reduction of 25 per cent. Although this reduction was instituted as a temporary expedient pending the introduction of new and more restricted membership contracts returning coverage to the 21-day basis and the establishment of better underwriting standards, it indicated the

¹ *Ibid.*, p. 19.

essentially insurance nature of the hospitalization plans and served to emphasize the necessity for a close application of the insurance technique to their management.

Out of their very considerable experience, the nonprofit associations have been able to derive some very interesting and presumably reliable statistics. The Committee on Hospital Service of the American Hospital Association has served as a clearing-house for this experience. Basing its conclusions upon data covering more than 300,000 subscriber years of membership and nearly 300,000 patient days of care, the committee estimates that subscribers to the plans require slightly less than 1 hospital day per subscriber year of membership. Females use approximately 50 per cent more care than males enrolled under corresponding circumstances, the average for fully employed males being 0.8 hospital day per year, for fully covered employed females 1.2 days per year.¹ The experience has varied with the type of membership. Pay-roll-deduction groups make the best showing with 0.6 day per year utilization by employed males in such groups, compared with 0.75 day by males in direct-remitting groups and 0.89 day by males in groups having no common employer. Single contracts, on either males or females, show a greater utilization of hospital facilities than do the family contracts with their broader distribution of risk and higher average premium per contract. Somewhat analogous to the jumbo lines in disability insurance, hospitalization groups experience a higher loss ratio on the more elaborate forms than on the simple ones. For example, in one plan the average utilization of semiprivate rooms was 0.9 day per year whereas the average for ward subscribers was 0.6 day.

The experience so far obtainable justifies certain conclusions. Subscribers enrolled on a pay-roll-deduction basis are demonstrably the most desirable risks with individual female subscribers the least desirable. The enrollment procedure must produce a balanced distribution as to age, sex, and physical characteristics. The frequency of hospital care increases with age of the membership-contract, necessitating the maintenance of adequate reserves. This the New York Insurance Department has recognized by requiring hospital associations in that state to accumulate

¹ REEDER, *op. cit.*, p. 6.

contingent surpluses equal to 4 per cent of all premiums earned since Jan. 1, 1937, in addition to the regular unearned-premium and claim reserves.

One of the most commendable achievements of the hospital associations has been their development of a large volume of insurance while maintaining an exceptionally low expense ratio. Originally, the New York Insurance Department permitted the associations to use 35 per cent of the premium for overhead and reserves. Later, this was reduced to 25 per cent. The premium is calculated on the basis of 75 per cent to cover claim costs, 15 per cent for expenses, and 10 per cent for reserves.¹ The associations have been able to hold their acquisition costs down by utilizing the group-enrollment procedure. Only one or two associations have been represented by commission agents, most of them relying on salaried solicitors. It remains to be seen whether it will be possible for the groups to maintain their early showing when the initial "volunteer" business has all been absorbed. In point of fact, what the future holds for the entire nonprofit hospitalization movement is a matter of conjecture. It offers some distinct advantages and suffers from some severe handicaps when compared with the hospitalization insurance offered by the accident-and-health companies, outlined in a following section.

Medical-service Plans.—Because group-hospitalization plans are designed to indemnify the insured member against but a part of his potential expense for treatment of injury or sickness, experimental medical-service plans have been undertaken in a number of localities. The states of Connecticut, Michigan, New York, Vermont, and Pennsylvania have enacted laws authorizing the incorporation of nonprofit, group medical-service associations. Pursuant to these statutes, widely differing plans have been projected or instituted in a number of communities, usually with the benediction if not active support of the local medical society.

The Michigan enabling act, passed in 1939, closely resembles the law providing for the establishment of nonprofit hospitalization associations. It empowers the Department of Insurance to license and supervise such corporations, which must maintain adequate working capital of not less than \$10,000 for a reasonable

¹ ROREM, *op. cit.*, p. 10.

length of time after establishment. The Commissioner of Insurance has the authority to approve or disapprove the contracts and rates of the corporation and prescribe reasonable and adequate reserves. Annual statements must be filed with the Department of Insurance.

The Michigan Medical Service, sponsored by the Michigan State Medical Society, was licensed under this act on Feb. 1, 1940, to provide state-wide medical care on the nonprofit plan. The organization issued two types of certificate, one providing for complete medical service, the other for surgical care and treatment only. All employed adults under 65 years of age, together with families, including children between the ages of 1 and 19 years, are eligible. Enrollment is limited to groups of 25 or more with at least 50 per cent of the group subscribing to the plan. Families whose income exceeds \$2,500 per year or individuals who earn in excess of \$2,000 annually are not accepted. The complete medical service certificate provides the following benefits:¹

1. Medical and surgical care from a doctor of medicine, chosen by the subscriber, including home, office, and hospital visits.

2. Consultation services and special medical services such as X-ray, laboratory, and anesthesia services performed by doctors of medicine.

3. Obstetrical services after membership for a period of 12 consecutive months.

4. Medical services necessary to establish a diagnosis for tuberculosis, venereal diseases, cancer, and nervous or mental disorders.

After the payment of the first \$5 incurred for medical service, subscribers are entitled in any one subscription year up to:

\$325 worth of medical services for individuals

\$550 worth of medical services for husband and wife

\$875 worth of medical services for a family

The certificate which provides benefits for surgical services only covers operative and cutting procedures performed by doctors of medicine for the treatment of diseases and injuries, provided that the subscriber is a bed-patient in a hospital.

¹ BROWER, H. O., "Development of Medical and Hospital Service Plans in Michigan," p. 5.

Maternity care is offered after 12 months of membership and diagnostic X-ray services are covered up to \$15 in any one subscription year.

The premiums charged by the Michigan Medical Service are given in the following table:

MICHIGAN MEDICAL SERVICE
(Monthly premium charges)

Type of cover	Complete medical service	Surgical service only
Individual.....	\$2.00	\$0.40
Husband and wife.....	3.50	1.20
Family.....	4.50	2.00

The benefits of the plan are limited to the professional service of doctors of medicine; dental care, nursing services, drugs, appliances, and hospitalization are not included.

Four months after incorporation, the Michigan Medical Service reported 61,786 subscribers under the Surgical Benefit Plan and 1,352 under the Medical Service Plan.

Although the fundamental principles of the Michigan association are common to most of the plans instituted elsewhere, no two are exactly alike because of the early experimental stage through which they are all passing. In Wisconsin, three plans have been projected, two operated by local medical societies, the other by cooperative lay groups. In New York and California, associations have been formed. All adopt the principle of free choice of the physician to be employed with payment by the association to the physician in proportion to the number of subscribers whom he treats. Premium rates vary from plan to plan, but the Michigan rates, quoted above, may be taken as typical. Some plans provide for deduction of the first \$5 to \$24 of care in any one year. Usually, tuberculosis, venereal diseases, insanity, drug or alcoholic addiction, and occupational injuries or disease are excluded from coverage, for facilities for the care of these conditions are already available.

Medical-service plans have not yet been sufficiently tested by experience to prove whether they are a sound means of providing

medical care on a prepayment basis. Many questions which have been raised concerning underwriting procedure, inherent insurability of the hazard, effect on preventive medicine, and quality of medical service offered, as well as costs of administration, have yet to be answered.

Hospitalization Insurance.—The same mass desire for economic security which gave such a tremendous impetus to the growth of hospital-sponsored group-service plans helped to carry the accident-and-health companies into fields of wider usefulness. As might be expected, the companies were quick to take advantage of this opportunity for increasing the sphere of their protection. Though hospital benefits of various kinds had been featured parts of many regular accident-and-health policies for years before 1931, the awakened public interest in problems arising out of the costs of hospital and medical care gave the companies their cue for the introduction of a wide variety of *hospitalization-reimbursement* forms.

The accident-and-health carriers, in drafting their forms, exercised a greater degree of both caution and originality than the nonprofit associations whose certificates follow a more standardized type. There are almost as many different hospitalization-insurance policies as there are companies issuing them. Originally about equally divided between individual and group handling, the later trend has been toward the group basis.

Among the forms available to individuals the *Advisory Forms* of the Bureau of Personal Accident and Health Underwriters represent the closest approach to uniformity by any considerable number of carriers. Advisory Form A provides benefits of \$5 per day for hospital room, \$5 daily nurse's fee, miscellaneous hospital expense up to \$25, and a schedule of fees for surgical operations, all subject to a total maximum limit of \$500 for any one disability. When issued to women, this form excludes benefits for pregnancy, childbirth, or miscarriage. Form B carries the same indemnities as Form A except that no allocation is made for hospital room, nurse's fee, or miscellaneous hospital expense, only the \$500 maximum limit being retained. Form C is similar to Form A with an additional exclusion ruling diseases of the generative organs of women out of the coverage. All three forms make the insurance effective 15 days after the

date of the policy; nurses' fees are payable for service in the hospital or elsewhere. There are no territorial restrictions in the policy.

Carriers associated with the Health and Accident Underwriters Conference, being less homogeneous, offer a wider range of forms. The average daily hospital-room indemnity in their policies is about \$4 although the benefit varies from \$1 to \$5 daily with hospital residence limited from 21 days to 13 weeks, the majority providing 30 days' coverage. Most forms allocate \$10 or \$15 to cover operating or delivery-room expenses with \$5 to \$15 for miscellaneous items such as X-ray examination, anesthesia, laboratory fees, and dressings. About half the forms include a schedule for surgical-fee reimbursement. Usually, with the smaller daily allowance their schedules provide a maximum of \$75 for the more serious abdominal operations. Other combinations reach \$150 or \$300. Only a relatively few of the Conference companies include indemnities for nurses' fees in their hospital policies. Less than one-fifth of these companies incorporated a medical-reimbursement indemnity in their contracts in 1939. Where used, these benefits were of the allocated variety calling for an indemnity of \$2 or \$3 per visit of the attending physician. The number of visits allowed ranged from 10 to 50 with further restrictions upon the number of calls per week for which benefits would be paid. Like the Bureau Advisory Forms, nearly all the policies of the Conference companies include the Standard Provisions, a few having special additions. Although the Standard Provisions, having been designed for loss-of-time coverage, are unsuited in some particulars for the hospitalization coverage, they appear to be the most satisfactory working conditions available and have the advantage of approximating the policy requirements of accident-and-health insurance with which many hospitalization policyholders are already familiar. The majority of the Conference companies exclude from their hospitalization coverage any injury or disease for which hospitalization benefits are payable under any workmen's-compensation law. About 20 per cent of the forms exclude contagious diseases, and about one-half exclude hernia. Venereal diseases are almost never covered. Maternity benefits are offered by about 50 per cent of the Conference companies after the policy has been in

force from 9 to 12 months. Ordinarily the hospitalization policy is effective as against sickness originating 30 days after the date of issue.

The Bureau Advisory Forms are designed for risks between ages 18 to 59. The usual age limits employed by the Conference companies are 16 or 18 to 60. A few accept risks at age 1 and as old as age 65 or 70.

Advisory Form A of the Bureau issued with a \$500 maximum limit is sold to males between ages 18 and 49 for \$20 annually, to females for \$32. Between ages 50 and 59, the premium is \$27.50 for men and \$44 for women. Form B, which is issued only to males, carries premiums of \$32 and \$44 for ages 18 to 49 and 50 to 59, respectively. Form C, designed for women, is rated at \$25 annually for ages 18 to 49 and at \$34.50 for policyholders between ages 50 to 59. All three Advisory Forms are available with a \$1,000 maximum limit for increased premiums.

The generally more restricted coverage issued by the Conference companies carries commensurately lower premiums. The rate for males ranges all the way from \$1.80 to \$32 annually, depending on the coverage. For the monthly-premium forms, the most common charge is \$1 per month. Rates for females are frequently quoted on a slightly higher basis and for children somewhat lower than for adult males.¹

It is the observation of many students of hospitalization insurance that this field lends itself particularly well to development by the group-insurance technique. Just as the success of the voluntary nonprofit hospital associations has been based largely upon an application of group-insurance principles, the insurance carriers have found that the economies in overhead, greater spread of the risk, and nominal premiums made possible by group handling recommend this approach. Profiting by their experience with group accident-and-health insurance, most companies which offer hospitalization insurance on the group basis have been able to devise fairly uniform premium rates, coverage, and underwriting procedure. Benefits for hospital-room expense caused by sickness or nonoccupational accident range from \$2 to \$5 per day with either a 31-day or a 70-day maximum the most

¹ *Report of the Special Committee on Hospital Insurance of the Health and Accident Underwriters Conference (1939)*, pp. 5f.

avored limits. Reimbursement for miscellaneous hospital expenses such as anesthesia, laboratory, and operating-room fees is provided up to a limit of five times the daily benefit. Surgical benefits may be added for an extra premium.

Group benefits are available to the employees covered immediately upon the effective date of the contract. Hospitalization benefits are payable when sickness or nonoccupational injury results in hospital confinement while the patient is employed and insured, or within 3 months following termination of the employee's insurance provided that the confinement results from total disability which has been continuous from the date of termination, or within 9 months following termination of the employee's insurance provided that the confinement results from pregnancy or resulting childbirth or miscarriage. In cases of temporary layoff where the hospitalization insurance is written in conjunction with a group life or disability policy, the hospital benefits will be continued in force as long as the other group policy is carried. The usual provisions for termination set out that the coverage ceases at the end of the period for which premium payments have been made, upon the payment of the maximum amount of benefits provided for any one disability (subject to reinstatement of the coverage upon the employee's return to active employment), or at the end of the policy year in which the employee attains age 70.

As with group life or disability policies, the plan may be on a noncontributory basis with the employer paying the full premium or on a contributory basis with the employees carrying all or a part of the cost. Hospitalization insurance is offered either in conjunction with group life or group accident-and-health policies or independently of such coverage to groups of at least 50 employees, or in contributory cases 75 per cent of those eligible, whichever number is greater. When the group coverage is written, no individual medical examination or evidence of insurability by any employee is required. However, if an employee does not take the coverage offered by a contributory plan within 1 month of becoming eligible, some companies provide that his subsequent application will be subject to medical examination at his expense. Group policies do not lay down any restrictions as to sex or occupation even though cognizance is

taken of the relative proportion of males and females in each group in the calculation of the premium. The greater liability to disability demonstrated by females requires a higher premium in groups where males constitute less than 90 per cent of the insured number. Mexicans and members of the black and yellow races also require more hospitalization than white males and are treated for rating purposes as females. Where extra health hazards exist, they are subject to extra premiums.

There are at least three common methods of setting up group-hospitalization benefits for a particular group. All employees may be insured for a uniform amount. Indemnities may be scheduled in accordance with weekly or monthly earnings or may be based upon the various classes of positions held in the organization. Considerable variation is possible as long as the plan established precludes selection against the insurer.

Premium rates for group-hospitalization and surgical insurance vary principally with two factors, the percentage of exposure which is on females and colored risks and the limit for which daily benefits will be paid. The range is illustrated by the table given below. Even in contributory groups operating upon the pay-roll-deduction system, the persistency of the business is well above that acquired in any other way.

GROUP-HOSPITALIZATION AND SURGICAL RATES
(Monthly premium per \$1 of daily benefits)

Percentage of exposure on female or colored risks, %	Hospitalization		Surgical-fee benefits schedule (\$150 maximum)
	31-day limit	70-day limit	
Less than 11.....	\$0.150	\$0.167	\$0.35
11 but less than 21.....	0.150	0.167	0.40
21 but less than 31.....	0.150	0.167	0.44
31 but less than 41.....	0.165	0.183	0.47
41 but less than 51.....	0.180	0.200	0.51
51 but less than 61.....	0.195	0.216	0.54
61 but less than 71.....	0.210	0.233	0.58
71 but less than 81.....	0.225	0.250	0.61
81 but less than 91.....	0.240	0.266	0.65
91 but less than 101.....	0.255	0.283	0.68

Surgical-fee premiums may be 25 or 50 per cent less in accordance with schedule chosen.

Formulas for conversion of monthly premium to

$$\text{Annual premium—monthly rate} \times \frac{12}{1.03}$$

$$\text{Semiannual premium—monthly rate} \times \frac{6.06}{1.03}$$

$$\text{Quarterly premium—monthly rate} \times \frac{3.06}{1.03}$$

Not all companies writing hospitalization insurance have seen fit to make coverage available for the insured employee's spouse or dependents. Some such plans are on the market, however, under group policies. One large carrier offers a group policy containing hospital benefits of \$3.50 daily for the employee and \$2.50 for the spouse. The aggregate of benefits for both insured and spouse is \$500 with a 70-day maximum limit in any 52 weeks' period for the spouse. The premium charged for such coverage is \$0.232 per month per dollar of daily indemnity as compared with \$0.167 per month on forms covering only the insured. Another carrier insures the spouse and dependent children over age 6 at its regular rates for each sex providing only that dependent relatives may not be insured in larger amounts than the employed member of the group. This business is written on a franchise basis with individual applications for each risk covered. This permits a higher degree of selection than is the case with regular group insurance.

One of the less common benefits included in some hospitalization insurance forms is a medical-treatment indemnity. A leading carrier which has featured this benefit will provide \$2 or \$3 per day during disability to reimburse for the expense of the physician's call. The benefit begins with the fourth treatment, and the limit for any one disability is 50 treatments. The monthly premium charged male risks for the medical treatment benefit is \$0.60 for \$2 per day or \$0.90 for \$3. For this coverage, female rates are \$0.70 and \$1.05 per month, respectively.

General Conclusions.—No development affecting disability insurance has created a wider divergence of opinion among accident-and-health-insurance men than the hospitalization movement. Much of the thinking on this subject, among company officials, political officeholders, and the general public alike,

has been confused and colored by a mistaken attempt on the part of some of the sponsors of voluntary nonprofit associations to treat the problem on a social basis rather than as a private-insurance function.

Both the voluntary nonprofit hospitalization groups and the insurance carriers offering hospitalization insurance offer some definite advantages peculiar to their coverage. Generally speaking, the nonprofit hospital groups charge lower rates than the insurance carriers and, for this reason, contend that their plans make hospital service available to a far wider clientele than would be possible if the field were restricted to the insurance companies. The rebuttal of this argument, however, lies not alone in the fact that the majority of their subscribers belong to the \$100- to \$200-monthly-income bracket but as well in the contention that the rates of the voluntary group-hospitalization associations are inadequate to provide even the limited benefits offered by their certificates of membership. The group-hospitalization associations expected in the beginning that 10 per cent of their members would be hospitalized for a period of 10 days each, or an average of 1 day per year per member. Most plans have showed a greater number than this hospitalized during the course of the year, but for a shorter period. It is the feeling of some that as long as new members can be added in large groups the inadequacy of the associations' rates will not become apparent. However, the associations cannot expect to continue the phenomenal growth which they have experienced during the last 3 years, and when the effect of a constant infusion of new blood into the group diminishes or terminates the associations may find themselves in financial difficulties. The situation with reference to the individual risk is thought to be much like that of the life-insurance company as the effect of its selection gradually wears off. As the American Medical Association points out, until 1936 most plans showed losses. During that year, however, as a consequence of the wide publicity received by the plans, there was a rapid enrollment which improved the financial position of the groups.¹ It is contended that the associations should look forward to an advancing loss ratio as their members become increasingly hospital minded. A very large number of insurance companies

¹ "Group Hospitalization," p. 237.

are now offering sound hospitalization coverage at attractive rates. Certain of the hospitalization forms, particularly the individual policies issued by the strictly commercial companies, have not been designed to appeal widely to the mass of people. On the other hand, there are many organizations which are competing aggressively for the mass market with contracts equal or superior to the benefits of hospitalization-association membership and at premiums well within the reach of the average employed person.

One advantage to which the group-hospitalization associations can point is the coverage offered dependents. Relatively few companies are offering insurance benefits which can be extended to the spouse and children of the insured. It remains to be seen whether such coverage can be offered on a profitable basis. In the main, the coverage given by the group-hospitalization associations includes a somewhat wider range of insureds at a lower per capita rate. Insurance coverage, generally speaking, makes provision for longer periods of disability than is the case with the voluntary nonprofit groups. Whereas they uniformly provide for 21 days of hospitalization, the insurance companies offer a 31- or 70-day limit. The insurance companies argue that, although the number of days spent in hospitals per admission is about 2 weeks, the truly important protection is against the prolonged disability which requires longer than average hospitalization. Although the average wage earner may be able to defray the costs of a short stay in the hospital, a long period of residence there will usually have a very serious and damaging effect upon his personal finances.

The insurance type of coverage has the further advantage that a schedule of surgical benefits can be and frequently is included. Such is not the case with the voluntary nonprofit coverage. It has been demonstrated that, in general hospitals, more than half of the patients admitted go to surgery. The experience during a period of 2½ years, with 52,832 patients who were insured under hospitalization plans, indicated that 57.8 per cent were surgical cases.¹ Mental, tubercular, and contagious cases, which are uniformly excluded from coverage under the group-hospitaliza-

¹ *Report of the Special Committee on Hospital Insurance of the Health and Accident Underwriters Conference (1939)*, p. 10.

tion plans, do not demonstrate so high an incidence of surgical treatment. The major portion of the expense for disabilities resulting in even short periods of hospitalization will arise from the necessity for a surgical operation. Tonsilectomies and appendectomies, two of the most common of all surgical operations, ordinarily require but a relatively brief commitment to the hospital. Unless, therefore, the insured has the benefit of a schedule of surgical-fee reimbursements, he himself must carry the major part of the financial burden of the disability. Some insurance carriers have gone beyond merely providing reimbursement for surgical care and have placed provisions in their contracts allowing benefits on an allocated basis for medical treatment. The nurse's fee benefit found in many hospital-insurance contracts is not granted by the voluntary nonprofit groups.

The medical profession is deeply interested in the development of hospitalization insurance. Through the American Medical Association, members have raised several pertinent questions bearing upon the desirability of voluntary nonprofit hospital associations.¹ One of the principal points raised by the doctors was whether the problem of hospitalization-care reimbursement should, from the standpoint of what is best for the patient, hospital, and physician, be placed on a cash basis and operated by the insurance companies or on a service basis with the hospitals contracting with the voluntary groups to render certain described services. The contention of the hospital groups has been that a service plan controlled by the hospital and the physician will return to the member a larger share of the premium in terms of hospital benefits.

Insurance companies, to operate successfully, must show an underwriting profit; and, because of the competition of the companies in the acquisition of insurance, the hospital managers have felt they could do the job more inexpensively. In reply to such an argument, the insurance companies can point out that the indemnification of loss due to hospital care is an insurance function, for which the hospitals were not set up and are not qualified, adding that to place the group-hospitalization association in control of the services of the contracting individual

¹ "Group Hospitalization," p. 228.

hospitals constitutes interference with the medical practice in these institutions.

That this point of view is held in part by many doctors is indicated by the Bureau of Medical Economics of the American Medical Association which has said,

No one can deny that elements of harm to the public, to the hospital and to the medical profession are intermingled with the contemplated benefits of the [group hospital] plans. Group hospitalization is neither a direct, simple method of paying for hospital bills nor a solution of the economic problems of hospital and patient alike. Its inauguration intensifies other problems which are as difficult of solution as those sought to be removed.¹

The same authority questions the wisdom of hospital managers in attempting to solve their financial problems by embarking upon an insurance function, stating,

The conclusion that seems inevitable is that considerable doubt is cast upon the wisdom of hospitals rushing into hospitalization insurance when insurance companies have feared to enter that field. Will hospitalization service corporations be able to avoid those forces which have created trouble for accident and health companies? The present accident and health policy is the result of almost a century of experience in the underwriting of personal accident and health insurance risks. Nearly every one of the accident and health companies would be glad to write such a policy if a premium income in excess of claims and expenses could be expected.²

It remains for time to tell whether the group-hospitalization associations will be able to avoid the pitfalls which lie in their path. They must learn to determine their basic costs and to avoid the addition of contract frills. They must anticipate the possibility of judicial broadening of the coverage and the temptation of widespread competitive sales effort to enlarge the sphere of their influence.

Though there has been a divergence of opinion among accident-and-health-insurance carriers as to the soundness and practicability of voluntary nonprofit group-hospitalization plans there is substantial agreement that the initial effect of their activity

¹ *Ibid.*, p. 230.

² *Ibid.*, p. 217.

on disability insurance has been salutary. The work of these groups has focused public attention upon one phase of the personal-security problem and to that extent has assisted the companies and agents in their task of educating the people how to protect themselves against the financial consequences of disability. Frequently the organization of a voluntary hospitalization plan has promoted tremendous public interest in this whole problem; and the plan, as such, has been made an effective ally of the accident-and-health-insurance salesman. He has been able to dovetail the short-time, limited coverage of the hospitalization groups into a complete personal protection program to the advantage of his prospect.

From the standpoint of the insuring public, one of the principal dangers of the widespread discussion of hospital insurance is the tendency to overemphasize its importance. It is but one phase of a complete personal-security program. By reason of its essential nature, loss-of-time protection must remain primary. But a relatively small percentage of all disabilities result in hospital confinement; hence the danger that overemphasis on hospital insurance may tend to distort its importance in comparison with that of income protection.

There is no irreconcilable conflict between hospital benefits provided by insurance companies and those offered by voluntary nonprofit hospitalization groups. The legitimate interest of accident-and-health-insurance men in the growth of the associations has been directed toward attaining a sound basis for their operation to the end that the public might be better served and no discredit reflected upon the risk-bearing functions undertaken by the associations. In large part, this effort has sought to secure recognition of the essentially insurance nature of the group-hospitalization associations' work and to make their operation subject to the same safeguards that are applied to insurance carriers. As at present set up in most states, hospital-service plans are exempt from every state, county, district, municipal, and school tax. The U.S. Bureau of Internal Revenue has ruled them exempt from Federal income taxes provided that they meet the requirements of an "organization for social welfare" as described in Sec. 101 (8) of the Revenue Act of 1936.¹

¹ ROREM, C. RUFUS, "Non-Profit Hospital Plans," p. 33.

Further, most of the state enabling acts, though nominally placing the associations under the supervision of the insurance departments, exempt them from most of the onerous provisions of the insurance code. As praiseworthy as the "non-profit" motive might seem to be, it must be remembered that its attainment is an ideal neither entirely practical nor in a democratic nation wholly desirable. The service plans are the offspring of the hospitals, conceived as a means of solving a hospital problem. As business institutions, hospitalization plans deprived of special dispensations can come no nearer reaching "protection at cost" than the insurance companies. They must earn a small, reasonable profit in order to persevere and progress. Else, in time of stress they will fail. The desirability of setting these plans apart from other insurers is open to question. The people they serve are in no way different, nor is the manner in which they serve vastly different from that of insurance companies.

In the spirit of fair competition, there can be no sound argument that these risk-bearing organizations should not carry the same tax load and comply with the same statutory requirements and insurance-department regulations as insurance carriers doing the same type of business. Only in this way can their subscribers be assured that the high standards which prevail in the insurance field have been adopted by the group associations. On this basis, the voluntary associations will eventually adopt sound insurance technique; or the insurance companies, profiting by the experience of the associations and adopting the desirable characteristics of their plan of operation, will assume their work. In either contingency, the insuring public will be the ultimate beneficiary. As a matter of fact, the majority of insurance executives welcome the service plans for the constructive part they have played and, properly administered, can continue to play in the indemnification of disability losses. There is a place in the field for sound, economically administered groups of this type.

CHAPTER XIV

CONCLUSION

Accident-and-health insurance has come of age. No one can deny the importance of a line of insurance which develops close to a quarter billion dollars of premiums each year. Even more important, no one who is familiar with the great good which accident-and-health insurance is doing would deny the beneficent social implications of its continued operation and progress. Generally speaking, the accident-and-health-insurance business is in the soundest position in its history. The weaknesses of infancy and the disturbances of adolescence are now a thing of the past. Disability underwriters today know pretty accurately what they are doing and where they are going. The early lessons have been well learned, and the dearly bought experience of the early thirties has left a deep impression which points to the continued application of conservative practices.

Having the advantage of hindsight, it is easy for the student to be critical of the mistakes which were made in the past. It is easy to forget the conditions under which the founders and early developers of the business labored. They did not turn back or give up because the way was uncharted; they did not abandon their ideals because they knew little about the new field into which they were entering. Rather, even though mistakes were made—mistakes which in our eyes take on the proportions of major blunders—they kept on laying the foundation upon which later comers could build better. Today the business has the advantage of their pioneering. Their mistakes have been noted, and provision has been made against their repetition.

The notable advances of even the last 10 years have provided better underwriting tools, statistical information for projecting accident-and-health insurance into the future, and an appreciation of the very real responsibility which the business has in

servicing one of the essential insurance needs. The underwriter, actuary, and agent now have at their command equipment which permits them to discharge the inherent responsibility of the carriers not alone to the individual policyholder but to the community as well, in the manner best calculated to meet the true needs of the insured and his dependents. There is sound protection available for practically every legitimate disability-insurance requirement. Policy forms are simple, liberal, and written at reasonable premium rates. They are flexible as to coverage and cost so that professionally trained agents can mold the protection to fit the prospect's individual needs.

Accident-and-health insurance will continue to go ahead because the field of its usefulness has hardly been explored. Today more than ever before, there is a keen public appreciation of the part that accident-and-health insurance should play in protecting the family circle. Past economic difficulties have intensified public interest in and directed attention to the value of human life and human working time. As a result, personal insurance has come to the forefront, rising to meet the enhanced responsibility which this greater public acceptance places upon it. Because accident-and-health insurance, like life insurance, is symbolic of practical democracy at its best, being built squarely upon the principles of individual initiative, thrift, and personal opportunity, it will continue to thrive as long as our government remains a democracy. The same innate qualities of character which have impelled Americans to accept their responsibilities as citizens create in them a keen sense of their duty to secure the happiness and welfare of themselves and their dependents. Democracy is but the machinery by which men are aided in the pursuit of happiness.¹ Nothing contributes more to the attainment of that happiness than the enjoyment of economic freedom, a goal attainable for most men only through the guarantee of the right to engage in individual enterprise. The institution of personal insurance gives them the opportunity to set their own levels as to the kind and amount of protection they wish and are able and willing to purchase in accordance with the spirit of self-reliance which is traditionally American. Just as no democracy

¹ WHITE, WILLIAM ALLEN, "American Insurance—Front Line Trench of Democracy," *Mutual Underwriter*, December, 1939, p. 5.

can thrive among peoples who must be "spoon-fed," so the tremendous volume of personal insurance in force today is a monument not to regimentation or superimposed social theory but rather to the untrammelled exercise of ingenuity and resourcefulness by a free people.

The healthy competition which prevails in accident-and-health insurance today is the best assurance that the interests of the public will be well served and that the individual carriers will be permitted enough flexibility to continue the development of ever better forms of protection.

With the need for disability protection more generally recognized than ever before, with more adequate facilities for meeting that need, and with an enlightened attitude prevailing throughout the business as to its responsibility for providing disability protection on a liberal, honest, and economical basis, accident-and-health insurance will carry on through years of ever greater usefulness.

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**SPECIMEN COMMERCIAL ACCIDENT INSURANCE
POLICY**

THE ZENITH INSURANCE COMPANY OF CHICAGO, ILLINOIS

JOHN WILLIAM DOE

against loss resulting directly and independently of all other causes from bodily injuries sustained during the term of this Policy and effected solely through accidental means, subject to the provisions, conditions and limitations herein contained, as follows:

The Limit of Payment under Part V is FIVE HUNDRED Dollars.

This Policy is issued in consideration of the payment of the premium of THIRTY FIVE Dollars, for the term of TWELVE months, to commence on the FIRST day of JULY 1940, beginning and ending at twelve o'clock noon, Standard Time, of the place where the Insured resides.

If such injuries shall cause continuous total disability, as defined in Part II, commencing within twenty days from the date of accident, and during the period of such continuous disability but within two hundred weeks from the date of accident shall result directly and independently of all other causes in any one of the losses enumerated in this

Part, or within ninety days from the date of accident, irrespective of total disability, shall result in like manner in any one of such losses, the Company will pay the sum set opposite such loss and in addition weekly indemnity as provided in Part II to the date of death, dismemberment, or loss of sight; but only one of the amounts so specified and such additional weekly indemnity will be paid for injuries resulting from one accident.

FOR LOSS OF

Life..... The Principal Sum

A Sum Equal to

FOR LOSS OF

Weekly Indemnity for

Both Hands or Both Feet or Sight of Both

Eyes..... 200 Weeks

One Hand and One Foot..... 200 Weeks

Either Hand or Foot and Sight of One Eye. 200 Weeks

Either Hand or Foot..... 100 Weeks

Sight of One Eye..... 65 Weeks

Thumb and Index Finger of Either Hand.. 50 Weeks

Or, in the event of the loss of both hands, or of both feet, or of the sight of both eyes, covered as above, if the Insured shall so elect in writing within ninety days after the date of such loss, the Company will pay the weekly indemnity so long as the Insured shall live, in lieu of the specific indemnity enumerated in this Part.

Loss shall mean with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to eyes, entire and irrecoverable loss of sight; with regard to thumb and index finger, actual severance through or above metacarpo-phalangeal joints.

Part II. Total and Partial Disability—Single Indemnity

TOTAL DISABILITY. A. Or, if such injuries, directly and independently of all other causes, shall, within twenty days from the date of accident, wholly and continuously disable the Insured and prevent him from performing any and every duty pertaining to his occupation, the Company will pay weekly indemnity at the rate hereinbefore specified for the period of such continuous total disability, but not exceeding fifty-two consecutive weeks. After the payment of weekly indemnity for fifty-two weeks as aforesaid the Company will continue the payment of weekly indemnity of the same amount thereafter so long as the Insured shall be wholly and continuously disabled by such bodily injuries from engaging in any occupation or employment for wage or profit.

PARTIAL DISABILITY. B. Or, if such injuries, directly and independently of all other causes, shall, within twenty days from the date of accident or immediately following a period of total disability covered under Section A, continuously disable and prevent the Insured from performing one or more important daily duties pertaining to his occupation, the Company will pay for the period of such disability, but not exceeding twenty-six consecutive weeks, a weekly indemnity of two-fifths of the amount payable for total disability.

No payment of weekly indemnity shall be made in case of any loss enumerated in Part I, except as therein provided.

Part III.

Elective Indemnity

The Insured, if he so elect in writing within twenty days from the date of accident, may take, in lieu of the weekly indemnity provided in Part II, indemnity in one sum according to the following Schedule if the injury is one set forth in said Schedule, but not more than one elective indemnity shall be paid for injuries resulting from one accident.

Schedule

If the single weekly indemnity for total disability payable under this Policy is Fifty Dollars the amounts named below shall be payable; if such weekly indemnity is greater or less than Fifty Dollars the amounts to be paid shall be increased or decreased proportionately.

For Loss by Removal:

Of one or more entire toes, .	\$400
Of one or more fingers (at least one entire phalanx),	300

For Complete Dislocation of Joints:

Hip,	600
Knee (patella excepted), ..	300
Bone or Bones of Foot (other than toes),	300
Ankle,	300
Wrist,	250
Elbow,	200
Shoulder,	150
One or more fingers or toes, .	50

For Complete Fracture of Bones:

Skull, both tables,	\$650
Thigh (shaft),	600
Arm, between elbow and shoulder (shaft),	600
Pelvis,	500
Shoulder Blade,	400
Leg (shaft),	400
Knee Cap,	400
Collar Bone,	300
Forearm, between wrist and elbow (shaft),	300
Foot (other than toes), ..	250
Hand (other than fingers),	250
Lower Jaw (alveolar process excepted),	150
One or more ribs, fingers or toes,	100

Part IV.**Double Indemnity**

Any amount payable under Parts I, II or III of this Policy shall be doubled if such injuries are sustained by the Insured

- (1) while a passenger in or upon a public conveyance provided by a common carrier for passenger service (including the platform, steps or running board of such conveyance);
- (2) while a passenger in an elevator car provided for passenger service only, other than elevator cars in mines; or are caused
- (3) by collapse of the outer walls or the burning of a building if the Insured is therein at the time of the collapse or commencement of the fire;
- (4) by the explosion of a steam boiler;
- (5) by a hurricane or tornado; or
- (6) by a stroke of lightning.

Part V. Hospital, Nurses, Medical and Surgical Expense

If such injuries, directly and independently of all other causes, shall require within twenty-six weeks from the date of accident, medical or surgical treatment, hospital confinement or the employment of a trained nurse, the Company will pay, in addition to any other indemnity to which the Insured may be entitled, the actual expense of such treatment, hospital charges and nurse's fees, up to an amount not exceeding the limit hereinbefore specified.

Part VI.**Identification and Registration**

If the Insured shall be physically unable to communicate with relatives or friends, the Company, upon receipt of a telegram or other message, will immediately transmit to them any information respecting him, and will defray all expenses necessary to put the Insured in their care, provided such expense shall not exceed the sum of One Hundred Dollars.

Standard Provisions

1. This Policy includes the endorsements and attached papers, if any, and contains the entire contract of insurance except as it may be modified by the Company's classification of risks and premium rates in the event that the Insured is injured after having changed his occupation to one classified by the Company as more hazardous than that stated in the Policy, or while he is doing any act or thing pertaining to any occupation so classified, except ordinary duties about his residence or while engaged in recreation, in which event the Company will pay only such portion of the indemnities provided in the Policy as the

premium paid would have purchased at the rate, but within the limits so fixed by the Company, for such more hazardous occupation.

If the law of the state in which the Insured resides at the time this Policy is issued requires that prior to its issue a statement of the premium rates and classification of risks pertaining to it shall be filed with the state official having supervision of insurance in such state, then the premium rates and classification of risks mentioned in this Policy shall mean only such as have been last filed by the Company in accordance with such law, but if such filing is not required by such law then they shall mean the Company's premium rates and classification of risks last made effective by it in such state prior to the occurrence of the loss for which the Company is liable.

2. No statement made by the applicant for insurance not included herein shall avoid the Policy or be used in any legal proceeding hereunder. No agent shall have authority to change this Policy or to waive any of its provisions. No change in this Policy shall be valid unless approved by an executive officer of the Company and such approval be endorsed hereon.

3. If default be made in the payment of the agreed premium for this Policy, the subsequent acceptance of a premium by the Company or by any of its duly authorized agents shall reinstate the Policy, but only to cover loss resulting from accidental injury thereafter sustained.

4. Written notice of injury on which claim may be based must be given to the Company within twenty days after the date of the accident causing such injury. In event of accidental death immediate notice thereof must be given to the Company.

5. Such notice given by or in behalf of the Insured or Beneficiary as the case may be, to the Company at _____ or to any authorized agent of the Company, with particulars sufficient to identify the Insured, shall be deemed to be notice to the Company. Failure to give notice within the time provided in this Policy shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

6. The Company, upon receipt of such notice, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not so furnished within fifteen days after the receipt of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting within the time fixed in the Policy for filing proofs of loss written proof covering the occurrence, character and extent of the loss for which claim is made.

7. Affirmative proof of loss must be furnished to the Company at its said office in case of claim for loss of time from disability within ninety days after the termination of the period for which the Company is liable, and in case of claim for any other loss within ninety days after the date of such loss.

8. The Company shall have the right and opportunity to examine the person of the Insured when and as often as it may reasonably require during the pendency of claim hereunder, and the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

9. All indemnities provided in this Policy for loss other than that of time on account of disability will be paid immediately after receipt of due proof.

10. Upon request of the Insured and subject to due proof of loss all accrued indemnity for loss of time on account of disability will be paid at the expiration of each four weeks during the continuance of the period for which the Company is liable, and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of due proof.

11. Indemnity for loss of life of the Insured is payable to the Beneficiary if surviving the Insured, and otherwise to the estate of the Insured. All other indemnities of this Policy are payable to the Insured.

12. If the Insured shall at any time change his occupation to one classified by the Company as less hazardous than that stated in the Policy, the Company, upon written request of the Insured, and surrender of the Policy, will cancel the same and will return to the Insured the unearned premium.

13. Consent of the Beneficiary shall not be requisite to surrender or assignment of this Policy, or to change of beneficiary, or to any other changes in the Policy.

14. No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of this Policy, nor shall such action be brought at all unless brought within two years from the expiration of the time within which proof of loss is required by the Policy.

15. If any time limitation of this Policy with respect to giving notice of claim or furnishing proof of loss is less than that permitted by the law of the state in which the Insured resides at the time this Policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

16. The Company may cancel this Policy at any time by written notice delivered to the Insured or mailed to his last address as shown by the records of the Company, with cash or the Company's check for the

unearned portion of the premiums actually paid by the Insured, and such cancellation shall be without prejudice to any claim originating prior thereto.

Additional Provisions

A. Wherever in this Policy the word "Company" is used it shall mean the Company issuing it, and wherever the word "Insured" is used it shall mean the applicant named in the copy of the application. Wherever the word "Beneficiary" is used it shall mean the person named as Beneficiary in the copy of the application or the person substituted as such. Wherever the word "injuries" is used it shall mean bodily injuries effected as described in the insuring clause.

B. The insurance under this Policy shall not cover death, disability or other loss caused directly or indirectly, wholly or partly, (1) by bodily or mental infirmity, (2) by bacterial infections (except pyogenic infections which shall occur with and through an accidental cut or wound), or (3) by any other kind of disease, or (4) by medical or surgical treatment (except such as may result directly from surgical operations made necessary solely by injuries covered by this Policy), or (5) by war or any act of war or suffered by the Insured while in military or naval service in time of war; nor (6) shall it cover any bodily injury which shall result in hernia; nor (7) shall it cover any injury, fatal or non-fatal, sustained by the Insured while in or on any vehicle or mechanical device for aerial navigation, or in falling therefrom or therewith, or while operating or handling any such vehicle or device; nor (8) shall it cover suicide or any attempt thereat (sane or insane).

C. Upon the occurrence of any of the losses enumerated in Part I of this Policy, all insurance hereunder, except as respects such loss, shall immediately cease, and upon payment of indemnity for such loss this Policy shall be surrendered to the Company.

D. No assignment of interest under this Policy shall be binding upon the Company unless and until the original or a duplicate thereof is filed at the Home Office. The Company does not assume any responsibility for the validity of an assignment. No change of beneficiary under this Policy shall bind the Company unless consent thereto is formally endorsed hereon by an executive officer of the Company. No provision of the charter, constitution or by-laws of this Company shall be used in defense of any claim arising under this Policy unless such provision is incorporated in full in this Policy. Failure to comply with any of the provisions contained in this Policy shall invalidate all claims hereunder.

E. The copy of the application endorsed hereon or attached hereto is hereby made a part of this contract which is made subject thereto.

F. This Policy may be renewed with the consent of the Company from term to term, by the payment of the premium in advance at the Company's premium rate in force at time of renewals.

In Witness Whereof, THE ZENITH INSURANCE COMPANY has caused this Policy to be signed by its President and a Secretary but it shall not be binding upon the Company unless countersigned by a duly authorized Agent or Cashier of the Company.

Secretary.

President.

Countersigned

APPENDIX II

SPECIMEN INDUSTRIAL DISABILITY POLICY

This Policy provides Indemnity for Loss of Life, Limb, Limbs, Sight or Time and other specified losses caused by Bodily Injuries effected through accidental means, and for Loss of Time and other specified losses caused by Disease, to the extent herein provided.

ZENITH INSURANCE COMPANY

CHICAGO, ILLINOIS

In Consideration of the statements and agreements in the application for this Policy, a copy of which is endorsed hereon or attached hereto and made a part hereof, and of the payment of the premium in advance

Hereby Insures JOHN WILLIAM DOE

by occupation a BANK CLERK classified AA
subject to the provisions, conditions and limitations herein contained or endorsed hereon or attached hereto, from noon of the date of this Policy, until noon of the first day of AUGUST, 1940, and for such time thereafter as renewal premiums paid to and accepted by the Company, as herein provided, will maintain this Policy in force.

The date of this Policy is JULY 1, 1940, and the MONTHLY premium is \$ 3.20.

The Principal Sum Indemnity of this Policy is ONE THOUSAND Dollars,

The Accident Monthly Indemnity is ONE HUNDRED Dollars,

The Sickness Monthly Indemnity is ONE HUNDRED Dollars.

INSURING This Policy insures against—(a) loss resulting directly and
CLAUSE. independently of all other causes from bodily injuries effected solely through accidental means sustained while this Policy is in force, and

(b) loss resulting from disease contracted after this Policy has been maintained in force for not less than thirty consecutive days from its date, as follows:

Part I. Death, Dismemberment and Loss of Sight Indemnity

(Accident Provision)

If such injuries shall cause continuous total disability, as specified in Part III, and during the period of such continuous disability but within twelve months from the date of accident shall directly and independently of all other causes result in any one of the losses enumerated in this Part, the Company will pay the sum set opposite such loss and in addition monthly indemnity as provided in Part III to the date of death, dismemberment or loss of sight, or if such injuries shall not cause total disability but shall in like manner and within ninety days from the date of accident result in any one of such losses, the Company will pay the sum set opposite such loss; but only one of the amounts so specified will be paid for losses resulting from one accident.

SECTION A—For Loss of

Life.....	The Principal Sum Indemnity A Sum Equal to the Accident Monthly Indemnity for
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SECTION B—For Loss of

Both Hands or Both Feet or Sight of Both Eyes...	Twenty Months
One Hand and One Foot..	Twenty Months
Either Hand or Foot and Sight of One Eye.....	Twenty Months

SECTION C—For Loss of

Either Hand or Foot.....	Ten Months
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SECTION D—For Loss of

Sight of One Eye.....	Five Months
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Loss shall mean with regard to hand or hands and foot or feet, actual severance through or above wrist or ankle joints; with regard to eye or eyes, entire and irrecoverable loss of sight.

Part II. Principal Sum Indemnity Increase

(Accident Provision)

For each consecutive month, immediately preceding the date of accident, for which renewal premium has been paid one percent. shall be added to the original amount payable For Loss of Life under Section A of Part I, but all such additions shall not exceed fifty percent. of such original amount.

Part III. Monthly Indemnity—Loss of Time from Injuries*(Accident Provision)*

TOTAL DISABILITY. A. If such injuries shall, within fourteen days from the date of accident, wholly and continuously disable the Insured and prevent him from performing any and every duty pertaining to his occupation, the Company will pay the Accident Monthly Indemnity for the period of such continuous total disability, but not exceeding sixty consecutive months.

PARTIAL DISABILITY. B. Or, if such injuries shall, within fourteen days from the date of accident or immediately following a period of total disability covered under Paragraph A, continuously disable and prevent the Insured from performing one or more important daily duties pertaining to his occupation, the Company will pay one-half of the Accident Monthly Indemnity for the period of such disability, but not exceeding six consecutive months.

No indemnity will be paid under this Part for any period of disability during which the Insured is not regularly attended by a physician; nor for a longer period than sixty consecutive months; nor in case of any loss enumerated in Part I, except as therein provided.

Part IV. Accident Double Indemnity*(Accident Provision)*

The Company will pay double the amount of indemnity otherwise payable under Section A, C or D of Part I, or under Part III if such injuries are sustained by the Insured, (1) while riding as a passenger in an elevator car provided for passenger service only, other than elevator cars in mines; or, (2) while riding as a passenger within the enclosed part of a railway passenger car provided by a common carrier for the exclusive use of passengers; or, (3) while riding as a passenger on board a steam vessel licensed for the regular transportation of passengers; or, (4) in consequence of the burning of a building while the Insured is therein and is not acting as a volunteer or paid fireman; provided such injuries sustained as outlined in divisions (1), (2) and (3) of this Part are due directly to the wrecking of such elevator car, railway car or vessel.

Part V. Air Travel Indemnity*(Accident Provision)*

If the Insured shall suffer loss by reason of such injuries sustained while riding as a fare paying passenger in a passenger aircraft owned and

provided by an incorporated passenger carrier, and operated by a licensed pilot on a scheduled trip over an established passenger route of such carrier, and between definitely established airports, the Company will pay the Accident Indemnity provided for such loss. However, no indemnity shall be payable for loss resulting from such injuries sustained in such aircraft while it is being used for a flight in excess of three hundred continuous nautical miles over water.

Part VI. Physician's Fees—Non-Disabling Injuries

(Accident Provision)

If such injuries do not result in death or disability or necessitate an operation named in Part XI, but shall require treatment by a physician, the Company will reimburse the Insured for the expense of such treatment, not exceeding an amount equal to one-fifth of the Accident Monthly Indemnity, provided, that the attending physician's receipt and statement on the Company's blanks are furnished the Company within ninety days from the date of accident.

Part VII. Monthly Indemnity—Loss of Time from Sickness

(Sickness Provision)

TOTAL DISABILITY AND CONFINEMENT.

A. If such disease shall wholly and continuously disable the Insured and prevent him from performing any and every duty pertaining to his occupation and shall necessarily confine him within the house and he is therein regularly visited by a physician, the Company will pay the Sickness Monthly Indemnity for the period of such continuous disability and confinement, not exceeding twelve consecutive months.

TOTAL DISABILITY NON-CONFINING.

B. Or, if such disease shall wholly and continuously disable the Insured and prevent him from performing any and every duty pertaining to his occupation but shall not necessarily confine him within the house and he is regularly treated by a physician, the Company will pay the Sickness Monthly Indemnity for the period of such continuous disability, not exceeding two consecutive months.

No indemnity will be paid under this Part for the first seven days of any period of disability, nor for a longer period than twelve consecutive months.

Part VIII. Permanent Disability Sickness Indemnity

(Sickness Provision)

If, during a period of disability covered by Part VII, such disease shall result in the Insured's irrecoverable loss of the entire sight of Both Eyes, or the permanent loss of the entire use of Both Hands, or Both Feet, or One Hand and One Foot, and provided the Insured survives such loss for one year, the Company will pay, in addition to other indemnity payable under this Policy, a sum equal to ten times the Sickness Monthly Indemnity.

Part IX. Hospital Confinement Indemnity

(Accident and Sickness Provision)

If, on account of such injuries for which double indemnity is not payable under Part IV or on account of such disease, the Insured shall be confined in a licensed hospital the Company will pay for the period of his continuous confinement therein during a period for which indemnity is payable under Part III or Part VII, additional indemnity equal to the Accident or Sickness Monthly Indemnity payable for Total Disability, but not in excess of two consecutive months on account of any one cause of disability.

Part X. Ambulance Expense

(Accident and Sickness Provision)

If on account of such injuries or such disease it is necessary to transport the Insured to a hospital in a motor vehicle, designed and used exclusively as an ambulance, the Company will reimburse him for the cost of such transportation in an amount not to exceed Ten Dollars, provided, that a receipted statement covering such expense is furnished the Company within ninety days from the date the expense is incurred and that not more than one such amount shall be payable as the result of any one accident or sickness.

Part XI. Surgical Operation Indemnity

(Accident and Sickness Provision)

If the Insured shall sustain injuries or contract disease covered by this Policy solely by reason of which any operation or operations named in the following Schedule shall be performed by a physician within ninety

days from the date of accident or commencement of disability by disease, the Company will pay the largest amount provided in said Schedule for any one of the operations so performed in addition to other indemnity payable under this Policy, provided, that not more than one such amount shall be payable as the result of any one accident or sickness.

Schedule

If the monthly indemnity for total disability payable under this Policy is One Hundred Dollars the amounts named below shall be payable; if such monthly indemnity is greater or less than One Hundred Dollars the amounts to be paid shall be increased or decreased proportionately.

Abdomen—Cutting into abdominal cavity for diagnosis or treatment of organs therein, except herniotomy,.....	\$75
Amputation of	
Thigh,.....	50
Arm, Leg or entire Foot,.....	35
Forearm or entire Hand,.....	20
Thumb or one or more Fingers or Toes (at least one entire phalanx),	10
Aneurism—Operation for, by ligation of artery,.....	30
Appendicitis—See Abdomen	
Bone—Removal of portion of bone (alveolar process excepted),...	10
Chest—Cutting into thoracic cavity for diagnosis or treatment of organs therein,.....	20
Dislocation—Reduction of	
Hip or Knee Joint (patella excepted),.....	30
Patella,.....	5
Shoulder, Elbow, Ankle or Wrist Joint,.....	20
Lower Jaw or Hand (other than fingers),.....	10
Thumb or one or more Fingers or Toes,.....	5
Ear, Nose or Throat—	
Any cutting operation,.....	10
Excision—Removal of	
Shoulder or Hip Joint,.....	75
Knee Joint,.....	50
Elbow, Wrist or Ankle Joint,.....	40
Coccyx,.....	10
Eye—Removal of.....	40
Any cutting operation on the eyeball,.....	10
Fracture—Reduction of	
Bones of the Pelvis (except coccyx),.....	50
Coccyx,.....	10

Thigh (femur),.....	50
Leg (tibia or fibula),.....	40
Knee Cap,.....	40
Upper Arm (humerus),.....	30
Lower Jaw (alveolar process excepted), Collar Bone or Shoulder Blade,.....	20
Forearm (ulna or radius),.....	20
Hand (other than thumb, finger or fingers),.....	15
Bones of Foot (other than toes),.....	15
Breast Bone,.....	10
Thumb or one or more Fingers,.....	5
Toe or Toes,.....	5
Nose, Rib or Ribs,.....	10
Goitre—Cutting operation for radical cure, arterial ligation excepted,.....	75
Gunshot wounds—Treatment of, not necessitating Amputation or any Cutting Operation into Abdominal Cavity,.....	10
Hydrophobia—Pasteur Treatment,.....	40
Incision for drainage,.....	5
Intestinal Obstruction—See Abdomen	
Kidney—See Abdomen	
Mastoiditis—Cutting operation for removal of diseased bone,....	40
Nerve—Cutting operation for stretching,.....	20
Paracentesis—Tapping of	
Abdomen,.....	20
Bladder,.....	15
Chest,.....	10
Ear Drum,.....	10
Hydrocele,.....	10
Joints,.....	10
Rectum—Cutting operation for radical cure of	
Hemorrhoids, external,.....	5
Hemorrhoids, internal,.....	20
Prolapsed Rectum,.....	20
Fistula in Ano,.....	20
Stricture of Rectum,.....	25
Skull—Cutting into cranial cavity,.....	75
Spine or Spinal Cord—	
Operation with removal of portion of vertebra,.....	75
Stone in Bladder—Removal of, by cutting or crushing operation,..	50
Stricture—Cutting operation (external) for Esophagus,.....	75
Tetanus (Lockjaw)—	
Injection of Antitoxin into Spinal Canal,.....	40

Trachea—Cutting into for removal of foreign bodies or for relief of difficult breathing,.....	30
Tumors—Removal of, by cutting operation	
Malignant,.....	20
Benign,.....	15
Varicose Veins—Cutting operation for radical cure,.....	20
Wounds—Suturing,.....	5
Any cutting operation not otherwise specified in this schedule,....	5

Part XII. Monthly Indemnity Increase

Indemnity payable under Part III or Part VII for loss originating during any period for which the Insured shall have paid twelve months' premium in advance shall be increased ten percent., or five percent. for loss originating during any period for which the Insured shall have paid six months' premium in advance.

Part XIII. Identification

If, because of such injuries, the Insured shall be physically unable to communicate with relatives or friends, the Company, upon receipt of a telegram or other message, will immediately transmit to them any information respecting him, and will defray all expenses necessary to put the Insured in their care, provided such expense shall not exceed the sum of One Hundred Dollars.

Part XIV. Grace in the Payment of Renewal Premiums

After this Policy has been maintained in continuous force by payment of premiums on or before the dates due for two months from its date or from the date of reinstatement after lapse, a grace of ten days will be allowed for the payment of subsequent renewal premiums, during which ten day period the insurance hereunder shall continue in force, subject otherwise to all of the terms of this Policy.

Part XV. General Provisions

A. This Policy shall not cover death, disability or other loss resulting wholly or partly, directly or indirectly from (a) injuries sustained or disease contracted while the Insured is in military or naval service in time of war or caused by war or any act of war; (b) injuries sustained while in or on, or in consequence of having been in or on, any vehicle or device for aerial navigation, or in descending or falling therefrom or therewith, or while adjusting, operating or handling any such vehicle or device (except as provided in Part V); (c) suicide or self-destruction, or any attempt thereat, while sane or insane; (d) venereal diseases or

syphilitic infection; nor (e) shall it cover loss of time resulting from disease unless the disability commences while this Policy is in force.

B. Any disability or loss caused wholly or partly, directly or indirectly by hernia, if otherwise covered under the terms of this Policy, shall be covered only under the Sickness Provisions anything herein to the contrary notwithstanding.

C. No provision of the charter or by-laws of this Company shall be used in defense of any claim arising under this Policy unless such provision is incorporated in full in this Policy. Failure to comply with any of the provisions contained in this Policy shall invalidate all claims hereunder. Indemnity as provided under this Policy is payable either for injuries or disease but not for both during any concurrent period of disability.

D. No assignment of this Policy or of any claim arising hereunder, or change of beneficiary, shall be binding on the Company unless approved in writing by an executive officer of the Company and such approval endorsed hereon or attached hereto. The Company does not assume any responsibility for the validity of an assignment. The Insured may at any time release the Company from any and all liability then existing or thereafter accruing to the beneficiary.

E. This Policy may be renewed, with the consent of the Company, for consecutive terms of one or more calendar months by payment in advance of renewal premium to the Company or to its duly authorized agent at or before noon of the day the preceding term expires. Each renewal shall terminate at noon on the first day of the calendar month next succeeding that for which premium has been paid.

F. Wherever in this Policy the word "Company" is used it shall mean the Zenith Insurance Company and wherever the word "Insured" is used it shall mean the applicant named in the copy of the application. Wherever the word "Beneficiary" is used it shall mean the person named as Beneficiary in the copy of the application or the person substituted as such. Wherever the word "noon" is used it shall mean twelve o'clock noon, Standard Time, of the place where the Insured resides. Wherever the words "injuries" and "disease" are used they shall mean bodily injuries effected and disease contracted as defined in the insuring clause. Wherever the words "disease" and "sickness" are used they are to be taken as equivalents of each other. Wherever the word "Physician" is used it shall mean a legally qualified physician or surgeon.

Standard Provisions

1. This Policy includes the endorsements and attached papers, if any, and contains the entire contract of insurance except as it may be

modified by the Company's classification of risks and premium rates in the event that the Insured is injured or contracts sickness after having changed his occupation to one classified by the Company as more hazardous than that stated in the Policy, or while he is doing any act or thing pertaining to any occupation so classified, except ordinary duties about his residence or while engaged in recreation, in which event the Company will pay only such portion of the indemnities provided in the Policy as the premium paid would have purchased at the rate but within the limits so fixed by the Company for such more hazardous occupation.

If the law of the state in which the Insured resides at the time this Policy is issued requires that prior to its issue a statement of the premium rates and classification of risks pertaining to it shall be filed with the state official having supervision of insurance in such state, then the premium rates and classification of risks mentioned in this Policy shall mean only such as have been last filed by the Company in accordance with such law, but if such filing is not required by such law then they shall mean the Company's premium rates and classification of risks last made effective by it in such state prior to the occurrence of the loss for which the Company is liable.

2. No statement made by the applicant for insurance not included herein shall avoid the Policy or be used in any legal proceeding hereunder. No agent has authority to change this Policy or to waive any of its provisions. No change in this Policy shall be valid unless approved by an executive officer of the Company and such approval be endorsed hereon.

3. If default be made in the payment of the agreed premium for this Policy, the subsequent acceptance of a premium by the Company or by any of its duly authorized agents shall reinstate the Policy, but only to cover accidental injury thereafter sustained and such sickness as may begin more than ten days after the date of such acceptance.

4. Written notice of injury or of sickness on which claim may be based must be given to the Company within twenty days after the date of the accident causing such injury or within ten days after the commencement of disability from such sickness. In event of accidental death immediate notice thereof must be given to the Company.

5. Such notice given by or in behalf of the Insured or Beneficiary, as the case may be, to the Company at Chicago, Illinois, or to any authorized agent of the Company, with particulars sufficient to identify the Insured, shall be deemed to be notice to the Company. Failure to give notice within the time provided in this Policy shall not invalidate any claim if it shall be shown not to have been reasonably possible to

give such notice and that notice was given as soon as was reasonably possible.

6. The Company upon receipt of such notice, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not so furnished within fifteen days after the receipt of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

7. Affirmative proof of loss must be furnished to the Company at its said office in case of claim for loss of time from disability within ninety days after the termination of the period for which the Company is liable, and in case of claim for any other loss, within ninety days after the date of such loss.

8. The Company shall have the right and opportunity to examine the person of the Insured when and so often as it may reasonably require during the pendency of claim hereunder, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

9. All indemnities provided in this Policy for loss other than that of time on account of disability will be paid immediately after receipt of due proof.

10. Upon request of the Insured and subject to due proof of loss all accrued indemnity for loss of time on account of disability will be paid at the expiration of each thirty days during the continuance of the period for which the Company is liable, and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of due proof.

11. Indemnity for loss of life of the Insured is payable to the Beneficiary if surviving the Insured, and otherwise to the estate of the Insured. All other indemnities of this Policy are payable to the Insured.

12. If the Insured shall at any time change his occupation to one classified by the Company as less hazardous than that stated in the Policy, the Company, upon written request of the Insured and surrender of the Policy, will cancel the same and will return to the Insured the unearned premium.

13. Consent of the Beneficiary shall not be requisite to surrender or assignment of this Policy, or to change of beneficiary, or to any other changes in the Policy.

14. No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty days after proof of loss has been

filed in accordance with the requirements of this Policy, nor shall such action be brought at all unless brought within two years from the expiration of the time within which proof of loss is required by the Policy.

15. If any time limitation of this Policy with respect to giving notice of claim or furnishing proof of loss is less than that permitted by the law of the state in which the Insured resides at the time this Policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

16. The Company may cancel this Policy at any time by written notice delivered to the Insured or mailed to his last address, as shown by the records of the Company, together with cash or the Company's check for the unearned portion of the premiums actually paid by the Insured, and such cancellation shall be without prejudice to any claim originating prior thereto.

17. If the Insured shall carry with another company, corporation, association or society other insurance covering the same loss without giving written notice to the Company, then in that case the Company shall be liable only for such portion of the indemnity promised as the said indemnity bears to the total amount of like indemnity in all policies covering such loss, and for the return of such part of the premium paid as shall exceed the pro rata for the indemnity thus determined.

18. Upon the payment of claim hereunder any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

IN WITNESS WHEREOF, ZENITH INSURANCE COMPANY has caused this Policy to be signed by its President and an Assistant Secretary but it shall not be binding upon the Company unless countersigned by a duly authorized Agent of the Company.

President
Ass't Secretary

Countersigned

Duly Authorized Agent.

APPENDIX III
SPECIMEN GROUP DISABILITY POLICY

**ZENITH
INSURANCE
COMPANY**

IN CONSIDERATION

of the application for this Policy made by

A. B. C. COMPANY

(HEREIN CALLED THE EMPLOYER)

a copy of which application is attached hereto and made a part hereof, and in consideration of the payment by the Employer of the initial premium and of the payment hereafter by the Employer, during the continuance of this Policy, of all premiums when they fall due as hereinafter provided,

HEREBY AGREES

to make the payments herein provided, with respect to the several Employees insured hereunder, in accordance with and subject to the provisions of this Policy.

The Provisions hereinafter contained are part of this Group Policy as fully as if recited over the signatures hereto affixed.

In Witness Whereof, the Zenith Insurance Company has caused this Policy to be executed this third day of January, 1940, to take effect as of the first day of January, 1940, which last date is the date of issue hereof.

ZENITH INSURANCE COMPANY

President

Secretary

Group Policy

Accident and Health Insurance

Contributory

Annual Distribution of Divisible Surplus

Section 1. DEFINITION OF THE WORD "EMPLOYEE."—The word "Employee" as used in this Policy means a full-time employee who is directly employed and compensated for services by the Employer.

Section 2. ELIGIBILITY OF EMPLOYEES.—All Employees employed on or prior to the date of issue of this Policy are eligible for insurance hereunder on the date of issue of this Policy. Employees employed subsequent to the date of issue of this Policy shall be eligible for insurance hereunder on the day immediately following the date of completion of three months of continuous service.

Section 3. EFFECTIVE DATES OF INSURANCE.—An Employee may become insured hereunder only by making written request to the Employer on forms furnished by the Insurance Company. The insurance on any Employee who makes such request on or before the date of his eligibility shall become effective on the date of his eligibility, provided

		X
X	X	X
X	X	X
X	X	X

he is actively at work on the date of his eligibility. The insurance on any Employee who makes such request after the date of his eligibility and on or before the thirty-first day following the date of his eligibility, or on or before the thirty-first day following the date of his return to active work if he is not actively at work on the date of his eligibility, shall become effective, provided he is then actively at work, on the

	X	X
X	X	X
X	X	X
X	X	X

date of such request. Any Employee making such request after such thirty-first day and any Employee requesting reinstatement of his insurance hereunder after his insurance hereunder has been discontinued in accordance with item (c) of Section 5 hereof, must furnish at his own expense evidence of insurability satisfactory to the Insurance Company before he may be insured hereunder. Any such insurance shall become effective, provided the Employee is then actively at work, on the

		X
X	X	X
X	X	X
X	X	X
X	X	date the Insurance Com-

pany accepts as satisfactory such evidence of insurability. The insurance on any Employee not actively at work on the date when his insurance hereunder would otherwise become effective shall become effective on the next following _____ day

on which he is actively at work.

Section 4. EMPLOYEES' CONTRIBUTIONS.—No Employee insured hereunder shall be required to contribute to the cost of his insurance more than the maximum amount specified in Section 6 hereof in accordance with the insurance in force hereunder on his account.

Section 5. CESSATION OF INSURANCE.—(A) The Accident and Health Insurance on any Employee insured hereunder shall automatically cease on the date of the termination of his employment, except that an Employee's Accident and Health Insurance hereunder shall continue during any period for which he is entitled to receive Weekly Benefits hereunder.

Termination of employment, for the purposes of Accident and Health Insurance hereunder, means cessation of active work as an Employee as defined in Section 1 hereof, except that

- (i) in case of the absence of an Employee from active work because of sickness or injury, his employment may, for the purposes of his Accident and Health Insurance hereunder, be deemed to continue until terminated by the Employer, or
- (ii) in case of the absence of an Employee from active work because of temporary lay-off, his employment may, for the purposes of his Accident and Health Insurance hereunder, be deemed to continue until terminated by the Employer but in no case beyond the expiration of a period of one month following the date

such lay-off commenced.

In the case of either of the above exceptions, the Accident and Health Insurance hereunder on such Employee shall automatically cease on the date of such termination of his employment by the Employer, as evidenced to the Insurance Company by the Employer, whether by notification or by cessation of premium payment on account of such Employee's Accident and Health Insurance hereunder.

(B) The Accident and Health Insurance on any disabled Employee insured hereunder shall automatically cease on the date of expiration of the maximum number of weeks for which Weekly Benefits are payable hereunder on account of such Employee's disability. The Accident and Health Insurance hereunder on any such Employee shall be reinstated

(c) The insurance on any Employee insured hereunder who shall have notified the Employer that his insurance hereunder is to be discontinued shall automatically cease on the _____ date

such

(D) In any event all insurance hereunder shall automatically cease upon the discontinuance of this Policy.

Section 6. AMOUNT OF INSURANCE.—The amount of insurance hereunder on any Employee shall be in accordance with the schedule set forth below and any increase _____ or decrease _____ in the amount of such insurance, in accordance with said schedule, shall become effective, provided the Employee is then actively at work, on the date of change in the Employee's earnings class

if such Employee is not then actively at work, such change in the amount of insurance shall become effective on the next following _____ day on which he is actively at work.

[illegible]

SCHEDULE OF INSURANCE AND EMPLOYEES' MAXIMUM CONTRIBUTIONS

<u>Class</u>	<u>Accident and Health Insurance (Weekly Benefit)</u>	<u>Maximum Amount Which the Employee May be Required to Contribute</u>
Employees earning annually:		
Less than \$1000.00	\$10.00	\$0.60 monthly
\$1000.00 but less than \$2000.00	14.00	0.84 monthly
\$2000.00 but less than \$5000.00	20.00	1.20 monthly
\$5000.00 or more	25.00	1.50 monthly

Section 7. INSURING CLAUSE.—Upon receipt by the Insurance Company of notice and satisfactory proof, as required herein, that any Employee while insured hereunder shall have become wholly and continuously disabled so as to be prevented from performing any and every duty of his occupation by either:

- (a) bodily injury which shall not have arisen out of, or in the course of, any employment for wage or profit, and which shall not have been intentionally self-inflicted while sane or insane, or
- (b) sickness for which the Employee is not entitled to benefits under any Workmen's Compensation Law or Act or any Occupational Disease Law or Act.

and that during the period of such disability such Employee shall have been under treatment therefor by a physician legally licensed to practice medicine.

THE INSURANCE COMPANY SHALL PAY to such disabled Employee, subject to the terms and limitations hereof, the Weekly Benefits to which he shall be entitled in accordance with Section 6 hereof, during the period the Employee is so disabled and under such treatment, provided, however, that

- (i) in no case shall such Weekly Benefits be payable for the first seven days of disability and
- (ii) in no case shall such Weekly Benefits be payable for more than thirteen weeks for any one continuous period of disability whether from one or more causes, or for successive periods of disability due to the same or related cause or causes.

FOR ALL DISABILITIES COMMENCING ON OR AFTER THE EMPLOYEE'S SIXTIETH BIRTHDAY AND WITHIN ANY TWELVE CONSECUTIVE MONTHS, A TOTAL OF NOT MORE THAN THIRTEEN WEEKS' BENEFITS SHALL BE PAID.

FOR DISABILITY CAUSED BY OR RESULTING FROM A PREGNANCY OR RESULTING CHILDBIRTH OR COMPLICATIONS THEREFROM, NOT MORE THAN SIX WEEKS' BENEFITS SHALL BE PAID.

Subject to due proof of claim, the Weekly Benefits will be paid to the Employee each week during any period of disability for which such Benefits are payable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of proof.

Section 8. NOTICE AND PROOF OF CLAIMS.—(A) Written notice of injury or sickness on which claim may be based must be given to the Insurance Company within twenty days after the date of the accident causing such injury or the commencement of disability resulting from such sickness. Proof of such injury or sickness must be furnished to the Insurance Company not later than ninety days after the termination of the period for which Weekly Benefits are payable hereunder.

The Insurance Company, upon receipt of the notice required by this Policy, will furnish such forms as are usually furnished by it for filing proofs of claim. If such forms are not received by the claimant within fifteen days after the Insurance Company receives such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to proof of claim upon submitting, within the time fixed in the Policy for filing proofs of claim, written proof covering the occurrence, character and extent of the disability for which claim is made.

Failure to furnish notice or proof within the time provided in this Policy shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as was reasonably possible.

(B) The Insurance Company shall have the right and opportunity to have a physician designated by it examine the person of the Employee when and so often as it may reasonably require during the pendency of claim hereunder.

	X	X
X	X	X
X	X	X
X	X	X

(c) No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty days after proof of claim has been filed in accordance with the requirements of this Policy, nor shall such action be brought at all unless brought within two years from the expiration of the time within which proof of claim is required by the Policy.

Section 9. ENTIRE CONTRACT.—This Policy and the application of the Employer, a copy of which is attached hereto, constitute the entire contract between the parties.

All statements made by the Employer shall, in the absence of fraud, be deemed representations and not warranties and no such statement shall avoid the insurance or reduce benefits under this Policy or be used in defense of a claim hereunder unless it is contained in the written application.

Section 10. AGENTS; ALTERATIONS.—No Agent is authorized to alter or amend this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted.

No change in this Policy shall be valid unless approved by an executive officer of the Insurance Company and evidenced by endorsement hereon, or by amendment hereto signed by the Employer and by the Insurance Company.

Section 11. CERTIFICATES.—The Insurance Company will issue to the Employer, for delivery to each Employee insured hereunder, an individual certificate which shall state the insurance to which such Employee is entitled under this Policy and to whom benefits are payable, and shall summarize the provisions of this Policy principally affecting the Employee. The word "certificate" as used in this Policy includes certificate riders and certificate supplements, if any.

Section 12. ASSIGNMENT.—The Employee's certificate is non-assignable and the insurance and benefits are non-assignable prior to a loss.

Section 13. REGISTER.—The Insurance Company shall keep a Register which shall show at all times the names of all Employees insured hereunder and the amount of insurance in force on each of such Employees, together with the date when any insurance became effective and the effective date of any increase or decrease in amount of insurance. Copy of said Register as of the date of issue of this Policy and copies of entries in said Register subsequent to said date shall be furnished by the Insurance Company to the Employer.

The initial premium is due on the date of issue of this Policy, and subsequent premiums shall be due on the first day of each calendar month

The initial Accident and Health Insurance premium due on the date of issue of this Policy and the Accident and Health Insurance premium due on any due date after the date of issue of this Policy shall be determined by applying the _____ monthly Accident and Health Insurance premium rate then in effect to each \$10.00 of Accident and Health Insurance Weekly Benefit then in force on all Employees, including those Employees who are receiving Weekly Benefits hereunder (subject, however, to premium adjustments, if any).

On written request of the Employer, approved by the Insurance Company, premium payments may, if not then so payable, be changed at any premium due date of this Policy, so as to be payable annually, semi-annually, quarterly, or monthly.

All premiums falling due under this Policy, including adjustments thereof, if any, are payable by the Employer, on or before their respective due dates, direct to the Insurance Company, at its Home Office or one of its Head Offices. The payment of any premium shall not maintain the insurance under this Policy in force beyond the day immediately preceding the next due date, except as provided in the next paragraph.

A grace period of thirty-one days, without interest charge, shall be granted to the Employer for the payment of any premium due after the initial premium, provided the Employer has not previously given written notice to the Insurance Company that this Policy is to be discontinued as of the due date of such premium, and during any such grace period this Policy shall continue in force.

If the Employer fails to pay any premium within the grace period, this Policy shall be discontinued on the last day of such grace period, but the Employer shall, nevertheless, be liable to the Insurance Company for the payment of all premiums then due and unpaid, together with the premiums for the grace period. If, however, written notice is given by the Employer to the Insurance Company, during the grace period, that this Policy is to be discontinued before the expiration of the grace period, this Policy shall be discontinued as of the date of receipt of such written notice by the Insurance Company or the date specified by the Employer for such discontinuance, whichever date is later, and the Employer shall be liable to the Insurance Company for the payment of the pro-rata premium for the period commencing with the last due date and ending with such date of discontinuance.

Section 15. PARTICIPATION IN DIVISIBLE SURPLUS.—This Policy is a participating contract and the Insurance Company shall annually ascertain and apportion any divisible surplus accruing under policies of this class. Any such divisible surplus apportioned to this Policy shall be paid in cash to the Employer or, upon written request from the Employer to the Insurance Company, shall be applied towards the payment of the aggregate of the premiums next falling due under this Policy. In either event, in the case of Contributory insurance, an amount equal to the excess, if any, of the Employers' aggregate contributions toward the cost of the insurance provided hereunder over the net cost of such insurance shall be distributed or applied by the Employer for the sole benefit of the Employees.

Section 16. RENEWAL PRIVILEGE.—This policy is issued for a period commencing with the date of issue and ending with the day immediately preceding January 1, 1941, on which date and on each anniversary of which date the Employer may renew this Policy for a further term of one year, provided the number of Employees then insured hereunder is, in the case of Contributory Insurance, not less than seventy-five per centum of the number of eligible Employees and, in the case of Non-Contributory Insurance, not less than the total number of eligible Employees, and provided in either case the number of Employees then insured hereunder is not less than fifty. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Section 14 hereof and based upon

such premium rate as may then be determined by the Insurance Company.

Section 17. ADDITIONAL PROVISIONS.—

		X
X	X	X
X	X	X
X	X	X
X	X	X
X	X	X
X	X	X
X	X	X
X	X	X
X	X	X

COPY OF EMPLOYER'S APPLICATION ATTACHED HERETO

APPENDIX IV
SPECIMEN GROUP INSURANCE CERTIFICATE
ZENITH INSURANCE COMPANY

SERIAL NO. 93 (HEREIN CALLED THE INSURANCE COMPANY)

Certifies that, under and subject to the terms and conditions of Group Policy No. Specimen , JOHN DOE , an Employee of

A.B.C. COMPANY

(HEREIN CALLED THE EMPLOYER)

is insured for Fourteen Dollars of Accident and Health Insurance Weekly Benefits on the effective date of this certificate, which amount is subject to change in accordance with the provisions of the Group Policy, as summarized in Section IV of this certificate.

If the Employee becomes, while in the employ of the Employer and while insured under the Group Policy, wholly and continuously disabled so as to be prevented from performing any and every duty of his occupation, by either

- (a) bodily injury which shall not have arisen out of, or in the course of, any employment for wage or profit, and which shall not have been intentionally self-inflicted while sane or insane, or
- (b) sickness for which the Employee is not entitled to benefits under any Workmen's Compensation Law or Act or any Occupational Disease Law or Act,

and during the period of such disability is under treatment therefor by a physician legally licensed to practice medicine, the amount of Weekly Benefits then in force on account of the Employee shall be paid to the Employee each week during the period the Employee is so disabled and under such treatment, provided, however, that

- (i) in no case shall such Weekly Benefits be payable for the first seven days of disability, and
- (ii) in no case shall such Weekly Benefits be payable for more than thirteen weeks for any one continuous period of disability whether from one or more causes, or for successive periods of disability due to the same or related cause or causes.

For all disabilities commencing on or after the Employee's sixtieth birthday and within any twelve consecutive months, a total of not more than thirteen weeks' benefits shall be paid.

For disability caused by or resulting from a pregnancy or resulting childbirth or complications therefrom, not more than six weeks' benefits shall be paid.

This certificate is non-assignable and the insurance and benefits are non-assignable prior to a loss. The insurance does not at any time provide paid-up insurance, or loan or cash values.

The insurance evidenced by this certificate, including the following pages, is provided under and is subject to all of the provisions of the Group Policy.

Effective JANUARY 1, 1940.

ZENITH INSURANCE COMPANY
President

NOTICES TO EMPLOYEE

This certificate is valuable to you and should be kept in a safe place.

SUMMARY OF PROVISIONS OF THE GROUP POLICY PRINCIPALLY AFFECTING THE EMPLOYEE

Section I. NOTICE AND PROOF OF CLAIMS

1. Written notice of injury or sickness on which claim may be based must be given to the Insurance Company within twenty days after the date of the accident causing such injury or the commencement of disability resulting from such sickness. Proof of such injury or sickness must be furnished to the Insurance Company not later than ninety days after the termination of the period for which Weekly Benefits are payable under the Group Policy.

The Insurance Company, upon receipt of the notice required by the Group Policy, will furnish such forms as are usually furnished by it for filing proofs of claim. If such forms are not received by the claimant within fifteen days after the Insurance Company receives such notice, the claimant shall be deemed to have complied with the requirements of the Group Policy as to proof of claim upon submitting, within the time fixed in the Policy for filing proofs of claim, written proof covering the occurrence, character and extent of the disability for which claim is made.

Failure to furnish notice or proof within the time provided in the Group Policy shall not invalidate nor reduce any claim if it shall be

shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as was reasonably possible.

2. The Insurance Company shall have the right and opportunity to have a physician designated by it examine the person of the Employee when and so often as it may reasonably require while Weekly Benefits are being claimed under the Group Policy.
3. No action at law or in equity shall be brought to recover on the Group Policy prior to the expiration of sixty days after proof of claim has been filed in accordance with the requirements of the Group Policy, nor shall such action be brought at all unless brought within two years from the expiration of the time within which proof of claim is required by the Policy.

Section II. PAYMENT OF CLAIMS

Subject to due proof of claim, the Weekly Benefits will be paid to the Employee each week during any period of disability for which such Benefits are payable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of proof.

Section III. CESSATION OF INSURANCE

1. The Accident and Health Insurance shall automatically cease on the date of termination of the Employee's employment, except that the Accident and Health Insurance on any Employee shall continue during any period for which he is entitled to receive Weekly Benefits under the Group Policy.

Termination of employment, for the purposes of Accident and Health Insurance, means cessation of active work as an Employee as defined in the Group Policy, except that

- (A) if the Employee is absent from active work because of sickness or injury, his employment may, for the purposes of his Accident and Health Insurance, be deemed to continue until terminated by the Employer in accordance with the terms of the Group Policy, or
 - (B) if the Employee is absent from active work because of temporary lay-off, his employment may, for the purposes of his Accident and Health Insurance, be deemed to continue until terminated by the Employer in accordance with the terms of the Group Policy, but in no case beyond the expiration of such limited period as may be prescribed in the Group Policy.
2. The Accident and Health Insurance shall automatically cease on the date of expiration of the maximum number of weeks for which

Weekly Benefits are payable under the Group Policy on account of the Employee's disability. It may be reinstated only if and when the Employee returns to active work for the Employer on full time.

3. If the Employee fails to make any contribution required by the Employer to the cost of his insurance under the Group Policy, such insurance shall automatically cease on the date of the expiration of the last period for which such contribution was made by the Employee.
4. The Accident and Health Insurance shall automatically cease upon the discontinuance of the Group Policy.
5. The cessation of the Employee's Accident and Health Insurance shall not affect any claim incurred before such cessation.

Section IV. SCHEDULE OF INSURANCE

CLASS	ACCIDENT AND HEALTH INSURANCE (WEEKLY BENEFITS)
Employees earning annually:	
Less than \$1,000.00.....	\$10.00
\$1,000.00 but less than \$2,000.00.....	14.00
\$2,000.00 but less than \$5,000.00.....	20.00
\$5,000.00 or more.....	25.00

Any change in the amount of the Employee's insurance in accordance with the Schedule of Insurance in the Group Policy, as outlined above, shall become effective as provided in the Group Policy, but in no case shall any change become effective on a date on which the Employee is not actively at work.

APPENDIX V
SPECIMEN REINSURANCE TREATY
REINSURANCE AGREEMENT

Entered into by and between ZENITH REINSURANCE CORPORATION, of CHICAGO, ILLINOIS (hereinafter called the CORPORATION), and PROTECTION INSURANCE COMPANY, of LINCOLN, NEBR. (hereinafter called the REINSURED):

ARTICLE I

1. *INSURING CLAUSE.* The REINSURED hereby agrees to reinsure with the CORPORATION, within the limits of reinsurance provided by this agreement, a portion of each risk which exceeds the REINSURED'S retention and the CORPORATION does hereby agree to accept such reinsurance and to indemnify the REINSURED for a proportionate amount, as hereinafter specified, of each loss sustained and paid by the REINSURED under the Principal Sum (Accidental Death), Capital Sum (Dismemberment and Loss of Sight), Weekly or Monthly Indemnity, and Medical Reimbursement (Accident) clauses of any personal accident or sickness policy of the REINSURED, upon a form hereinafter specified, which is issued or renewed to become effective at or after 12:01 A.M., July 1, 1940; this reinsurance shall be subject to all of the terms, conditions, and limitations hereinafter set forth, and reinsurance shall become effective only upon policy forms approved by the CORPORATION and included hereunder.

2. *RISKS COVERED.* Reinsurance shall be restricted to standard white male risks between the ages of 16 and 70 years inclusive, and standard white female risks between the ages of 16 and 60 inclusive, classified as not more hazardous than "B" in

the REINSURED'S occupational classification manual, filed herewith by the REINSURED and accepted by the CORPORATION. Incorrectly classified risks shall be properly classified by the CORPORATION and the premium therefor paid by the REINSURED accordingly therewith.

This reinsurance shall not cover guaranteed renewable policies of insurance or clauses in policies allowing recovery for lifetime disability from sickness or for total and permanent sickness disability, regardless of whether or not any of the following policy forms of the REINSURED contain any such clause or clauses. It is specifically understood and agreed that wherein the REINSURED'S policy forms allow recovery for disability from sickness for a period longer than twelve (12) months, the proportionate liability of the CORPORATION under any policy contracts upon any of such forms of the REINSURED shall be limited to payment of indemnity for a period of twelve (12) months as respects any single claim for sickness disability insurance or any one sickness. After payment by the CORPORATION of said twelve (12) months' indemnity, the CORPORATION'S liability as respects any such continuing sickness shall terminate.

ARTICLE II

1. *FORMS.* Reinsurance shall apply to policy and rider forms of the Reinsured which are filed with and approved by the CORPORATION, it being understood and agreed that the REINSURED may submit to the CORPORATION from time to time policy and rider form or forms by letter or together with cessions of reinsurance, and the CORPORATION will either approve and file the said form or forms to which the said cessions of reinsurance may apply, or reject the form or forms and cessions of reinsurance in the event the form or forms prove unacceptable, but the CORPORATION shall remain liable upon cessions under such unacceptable policy or rider forms for a period of thirty (30) days from the effective dates of any such cessions of reinsurance and the policy contracts under which such cessions are reported. Reinsurance shall not be in effect, however, except as above provided, unless the REINSURED has specific acknowledgement and approval from the CORPORATION of such subsequently submitted form or forms,

2. *AMOUNT REINSURED.* The REINSURED shall retain in every case on any one individual insured: Five Thousand Dollars (\$5000.00) of single Principal Sum benefits, Five Thousand Dollars (\$5000.00) of single Capital Sum benefits, Twenty-five Dollars (\$25.00) of single Weekly Accident Indemnity, One Hundred Dollars (\$100.00) of single Monthly Accident Indemnity, together with Double Indemnity appertaining thereto, Twenty-five Dollars (\$25.00) of Weekly Sickness Indemnity, One Hundred Dollars (\$100.00) of Monthly Sickness Indemnity, and One Thousand Dollars (\$1,000.00) of Medical Reimbursement (Accident). The remainder of single Principal Sum benefits, single Capital Sum benefits, single Weekly and Monthly Accident Indemnity, Weekly and Monthly Sickness Indemnity, and Medical Reimbursement (Accident) shall be reinsured with the CORPORATION hereunder, subject to the following limits of acceptance on the part of the CORPORATION upon any one individual insured:

Classes	Principal Sum	Capital Sum	Weekly Indem- nity	Monthly Indem- nity	Medical Reim- bursement (Accident)
AAA	\$10,000.00	\$10,000.00	\$50.00	\$200.00	\$2000.00
AA	7,500.00	7,500.00	37.50	150.00	1500.00
A	5,000.00	5,000.00	25.00	100.00	1000.00
B	1,000.00	1,000.00	None	None	None

In the event that several benefits are covered by an accident or accident and health policy or policies issued to any one individual insured, reinsurance shall be ceded in the same proportion on all benefits covered by the policy or policies issued to such individual. If the amounts of these several benefits are unlevel with respect to the retentions of the REINSURED, as above described, the benefit requiring the largest proportion of reinsurance shall determine the proportion of all benefits to be reinsured, the entire amount on any one individual to be reinsured in the same proportion.

The CORPORATION shall be liable for the proportionate amount of Double Indemnity, accumulations, and additional benefits, if any, appertaining to its single Principal Sum, single Capital Sum, and single Weekly and Monthly Accident Indemnity reinsurance.

3. *REINSURANCE PREMIUM.* The REINSURED shall pay to the CORPORATION for reinsurance herein provided the gross premium charged by the REINSURED for the fractional portion of each policy reinsured with the CORPORATION, less a commission of Thirty Percent (30%). The REINSURED shall pay all taxes in connection with such reinsurance premiums.

ARTICLE III

1. *ATTACHMENT OF LIABILITY.* With respect to each cession of reinsurance hereunder, the CORPORATION shall be liable for only those losses which result from accidents occurring on or after the effective date of such cession or from sickness disabilities beginning on or after such date.

2. *LIABILITY BEGINS.* Subject to the provision of Section 1 of this article, the liability of the CORPORATION on each risk, with respect to policies issued at or after 12:01 A.M., July 1, 1940, shall commence simultaneously with that of the REINSURED and, with respect to policies renewed at or after that time and date, shall commence at the effective time and date of such renewal, provided that the REINSURED shall dispatch advice of each reinsurance cession to the office of the CORPORATION at Chicago , Illinois , within ten (10) days (Sundays and holidays excepted) after the effective date of reinsurance on each policy issued or renewed by the REINSURED at its Home Office. If a policy shall be issued by a branch office of the REINSURED, the REINSURED shall dispatch reinsurance advice to the office of the CORPORATION in Chicago , Illinois , within ten (10) days (Sundays and holidays excepted) after receipt in the Home Office of the REINSURED of notice of issuance of said policy.

Notwithstanding anything to the contrary herein contained, it is expressly understood and agreed that if the REINSURED cedes to the CORPORATION reinsurance on an individual

insured on which the CORPORATION is already carrying its limit, the REINSURED shall upon notification of such fact by the CORPORATION take immediate steps to substitute other reinsurance therefor, the CORPORATION remaining liable under such cession until such substitution is effected, provided, however, that the CORPORATION'S liability thereunder shall in no event extend for more than sixty (60) days beyond the time of such notification.

The CORPORATION may refuse to renew any cession hereunder by giving written notice to the REINSURED at least ninety (90) days prior to the renewal date.

3. *DELAYED ADVICES.* If any reinsurance cession shall inadvertently not be advised to the CORPORATION within the above ten (10) days, liability on the part of the CORPORATION shall nevertheless attach, provided, however, that the inadvertent error or omission in reporting reinsurance to the CORPORATION is discovered within two (2) years of the date on which such error or omission first occurred, the REINSURED shall in every such case furnish the CORPORATION with reasonable proof of the bona fide nature of such error or omission.

ARTICLE IV

1. *ADVICE OF CESSIONS.* All reinsurance cessions shall be numbered in consecutive order beginning with No. 1, and shall be reported, as above prescribed, on forms mutual satisfactory to the REINSURED and the CORPORATION.

2. *MONTHLY REPORT.* The REINSURED shall render to the CORPORATION a monthly bordereau or account current, recapitulating all new cessions reinsured during the month, and showing all cessions renewed, cancelled, or lapsed during the current month. Such monthly bordereau or report shall be furnished by the REINSURED to the CORPORATION within fifteen (15) days after the close of the month treated, and shall be followed by remittance covering the net balance due the CORPORATION thereon, such remittance to be made within seventy-five (75) days following the close of the month treated. Credit for return premiums in connection with cancellations or terminations shall not be allowed by the CORPORATION, unless such cancellations or terminations are reported to the

CORPORATION within ninety (90) days after the date upon which each respective cancellation or termination becomes effective.

ARTICLE V

1. *CLAIM REPORT.* The REINSURED shall notify the CORPORATION within ten (10) days after knowledge of any claim in which the CORPORATION is or might be interested, sending copies of all reports and other documents in connection with said claim as adjustment proceeds. Such notice shall be a condition precedent to liability of the CORPORATION upon said claim.

2. *ADJUSTMENT.* It is mutually agreed that the CORPORATION may be represented in the adjustment of each and every claim reinsured hereunder and may control the negotiations where the liability of the CORPORATION is greater than that of the REINSURED. Any special expense other than ordinary overhead and salaries of regular employees of the parties hereto shall be divided between the CORPORATION and the REINSURED in proportion to the amounts of their respective interests in the final payment to the claimant.

3. *SETTLEMENT.* This reinsurance is pro rata reinsurance and upon each and every claim hereunder as finally adjusted with the claimant, the liability of the CORPORATION shall be in proportion to the liability originally assumed by it upon the face amount of the policy.

Immediately upon receipt of satisfactory evidence of settlement of a claim, the CORPORATION will pay to the REINSURED its portion of the settlement.

4. *ANNUAL REPORT.* The REINSURED shall forward to the CORPORATION prior to the 20th. day of January of each year a statement of each reinsured claim outstanding under this agreement, such statement being completed as of the 31st. day of December last past, and showing the amount claimed or the estimated value of the loss.

ARTICLE VI

1. *ACCESS TO RECORDS.* The CORPORATION may peruse at all reasonable times at the office of the REINSURED,

the books, records, files, documents, and papers appertaining to risks reinsured under this agreement, and shall be furnished upon application with the original file bearing upon any claim settlement hereunder, but it is understood and agreed that the insurance business in which the CORPORATION receives a reinsurance interest under this agreement is the absolute property of the REINSURED, and the CORPORATION agrees not to use any information received with regard to such business for any purpose other than that contemplated in this agreement.

ARTICLE VII

1. *AMENDMENT.* This agreement may be altered or amended in any of its terms and conditions by mutual consent of both parties endorsed hereon or by an instrument in writing attached hereto and formally signed. Should the laws of any state embraced in this agreement, or the ruling of the Insurance Department at any time render illegal the arrangements herein made, this agreement may be immediately terminated or amended to comply with any such conflicting law or ruling in so far as it relates to future operations or business in such state, after either party gives notice thereof in writing to the other party.

ARTICLE VIII

1. *EFFECTIVE DATE.* This agreement shall become effective at 12:01 A.M. on the first day of July, 1940.

2. *CANCELLATION.* This agreement may be terminated at any time by either party hereto, by written notice mailed to the other party under registered cover, stating at what time not less than three calendar months after the date of mailing such notice, cancellation shall be effective. Unless otherwise agreed, the CORPORATION shall continue to participate in all the insurance coming within the terms of this agreement, issued or renewed by the REINSURED before the date upon which cancellation becomes effective.

By mutual consent, all reinsurance hereunder may be cancelled at any agreed date after the termination of this general agreement, but otherwise all such reinsurance shall remain in full force and effect until the next premium due date of each respective

cession of reinsurance. Any cancellation of this reinsurance, effected under any provision of this agreement, shall be subject to the return of unearned premium.

In the event of lapsation or cancellation of any reinsurance cession hereunder, the CORPORATION shall not be liable, in connection with such reinsurance cession, for any loss which results from an accident occurring after the effective time and date of lapsation or cancellation or from sickness disability beginning after the said time and date.

3. *OTHER REINSURANCE.* The REINSURED may at any time effect elsewhere or with other companies, any reinsurance not within the scope of this agreement or which, by the laws of any state or ruling of supervising state officials, are not permissible hereunder.

4. *CONCURRENT REINSURANCE.* Should the REINSURED have other valid and collectible reinsurance against loss covered hereby, the REINSURED shall not be entitled to receive from the CORPORATION a larger portion of the reinsurance against such loss than the amount hereby reinsured bears to the whole amount of reinsurance carried by the REINSURED against such loss, subject to the return of unearned premium.

IN WITNESS WHEREOF, the parties hereto have caused these presents to be signed in duplicate by their respective executive officers as of June 26, 1940.

ZENITH REINSURANCE CORPORATION

President

Secretary

PROTECTION INSURANCE COMPANY

President

Secretary

APPENDIX VI-A

SPECIMEN PRELIMINARY CLAIM FORM

Preliminary Notice of Injury or Sickness ZENITH INDEMNITY COMPANY NEW YORK, N. Y. ACCIDENT AND HEALTH DEPARTMENT				
Name:			Policy form	and number
Address:				
Residence (Street)		(City)	(State)	
Business (Street)		(City)	(State)	
Present Occupation and Employer (describe duties fully)				
Date of commencement of disability.	A.M.		P.M.	
If injury, state where and how the accident occurred.				
Nature of Injury or Illness.				
Are you now disabled?		Totally?		Partially?
I anticipate disability as follows:	TOTAL from day 19 to day 19 PARTIAL from day 19 to day 19 It is understood these dates are approximated from date of this form			
Name and address of Attending Physician.				
Name of Company, dates and amounts of other Accident and Health or Benefit Insurance carried.				
By furnishing this blank the Company shall not be held to admit the validity of any claim or waive the breach of any condition of the policy.				
Date		Signed..... Insured		

APPENDIX VI-B

SPECIMEN ACCIDENT CLAIM PROOF

Proof of Loss-Accident ZENITH INDEMNITY COMPANY NEW YORK, N. Y. ACCIDENT AND HEALTH DEPARTMENT									
Name:							Policy form and number		
Address.									
Residence (Street)					(City)		(State)		
Business (Street)					(City)		(State)		
Present Occupation and Employer (Describe duties fully.)									
Date and place of birth					Height and Weight			Average Weekly Earnings	
Mo	Day	Year	Place		Ft.	in.	lbs.	\$	
Date and time of accident			Mo	Day	Year			A.M. P.M.	
Where and what were you doing?									
How did accident occur?									
Nature of Injury									
Total Disability— (Means period during which you were prevented from performing any and every duty of your occupation)				From		19		o'clock M	
				To		19		o'clock M	
				I first attended to part of my work on day of 19					
Partial disability— (Means period during which you were prevented from performing one or more important daily duties of your occupation)				From		19		o'clock M.	
				To		19		o'clock M.	
Name the duties you were unable to perform during partial disability									
Nature and date of any operation performed as result of Injury									
If confined in a regular Hospital state.				Name		Address			
				From		19		o'clock M.	
				To		19		o'clock M.	
If attended full time elsewhere by a graduate nurse state				Name		Address			
				From		19		o'clock M.	
				To		19		o'clock M.	
Give Names of Companies, dates and amounts of all other Accident and Health policies carried on date of accident									
Give names of Companies dates and amounts of all prior claims made by you.									
<p>By furnishing this blank and investigating the claim, the Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the Policy</p> <p>Sworn to before me at</p> <p>this day of 19.....</p> <p style="text-align: right;">Signed _____ Insured _____</p> <p style="text-align: center;">Notary Public or Justice of the Peace</p>									

(Over)

APPENDIX VI-C

SPECIMEN SICKNESS CLAIM PROOF

Proof of Loss-Sickness ZENITH INDEMNITY COMPANY NEW YORK, N. Y. ACCIDENT AND HEALTH DEPARTMENT									
Name: _____						Policy form and number _____			
Address: _____									
Residence (Street) _____				(City) _____		(State) _____			
Business (Street) _____				(City) _____		(State) _____			
Present Occupation and Employer (Describe duties fully.) _____									
Date and place of birth				Height and Weight			Average Weekly Earnings		
Mo.	Day	Year	Place	Ft	in	lbs	\$		
What Disease caused the disability?									
When did you first know you had this Disease?									
Total Disability— (Means the period during which you were prevented from performing any and every kind of duty of your occupation)				From		19		o'clock	M
				To		19		o'clock	M
				I first attended to part of work on		day of	19		
How long during above period were you confined to the house?				From		19		o'clock	M
				To		19		o'clock	M
*Partial Disability— (Means the period during which you were prevented from performing a material portion of the duties of your occupation)				From		19		o'clock	M
				To		19		o'clock	M
*If illness caused operation state nature and date performed. _____									
*A—If confined in a regular Hospital state:				Name		Address			
				From		19		o'clock	M
				To		19		o'clock	M
*B—If attended full time elsewhere by a graduate nurse state				Name		Address			
				From		19		o'clock	M
				To		19		o'clock	M
Give names of Companies, dates and amounts of all other Accident and Health policies carried on date of illness _____									
Give names of Companies, dates and amounts of all prior claims made by you _____									
<p>*NOTE: IF THIS POLICY DOES NOT PROVIDE PARTIAL DISABILITY, SURGICAL, HOSPITAL OR NURSE'S INDEMNITY, QUESTIONS RELATING THERETO NEED NOT BE ANSWERED</p> <p>By furnishing this blank and investigating the claim, the Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the Policy.</p> <p>Sworn to before me at _____</p> <p>this _____ day of _____ 19 _____</p> <p style="text-align: right;">Signed _____ Insured</p> <p style="text-align: center;">Notary Public or Justice of the Peace</p>									

(OVER)

APPENDIX VI-D

SPECIMEN PHYSICIAN'S CLAIM REPORT

Certificate of Attending Physician <i>(To be furnished without expense to the Company)</i>		Commercial Accident Claim
THE BLANK INSURANCE COMPANY 100 Main Street St. Louis, Missouri		
1. Patient's name and address.	Name	Address
2. Describe and locate accurately character and extent of injury		
3. Complications, if any.		
4. Describe the present condition of injured parts.		
5. Prognosis		
6. If fracture or dislocation, state whether complete or incomplete. If fracture of long bones, state whether fracture is through head or shaft.		
7. If injury necessitated surgical operation, please give date and describe fully.		
8. Give details of any history of physical impairments which may have contributed to lengthen period of disability.		
9. Give date of first and last consultation or treatment.	First Date..... Last Date.....	
10. How many times did you see claimant for these injuries?		
11. In your opinion how long was he disabled from performing any and every kind of duty pertaining to his occupation?	Total Loss of Time.....weeks.....days	
12. In your opinion how long was he disabled from performing one or more important daily duties pertaining to his occupation?	Partial Loss of Time.....weeks.....days	
Date..... Attending Physician. Graduate of..... Address in Full. <div style="text-align: center; font-size: small;">Medical School.</div>		

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